ISSUES RELATING TO ALL-PAYER FRAUD AND ABUSE

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES

ONE HUNDRED THIRD CONGRESS

FIRST SESSION

MARCH 8, 1993

Serial 103–3

Printed for the use of the Committee on Ways and Means

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ISSUES RELATING TO ALL-PAYER FRAUD AND ABUSE

MONDAY, MARCH 8, 1993

HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON HEALTH,
Washington, D.C.

The subcommittee met, pursuant to call, at 2 p.m., in room B–318, Rayburn House Office Building, Hon. Fortney Pete Stark (chairman of the subcommittee) presiding.

[The press release announcing the hearing follows:]

FOR IMMEDIATE RELEASE
TUESDAY, MARCH 2, 1993

PRESS RELEASE #4
SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
1102 LONGWORTH HOUSE OFFICE BLDG.
WASHINGTON, D.C. 20515
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**THE HONORABLE PETE STARK (D., CALIF.), CHAIRMAN,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON WAYS AND MEANS, U.S. HOUSE OF REPRESENTATIVES,
ANNOUNCES A HEARING
ON
ISSUES RELATING TO ALL-PAYER FRAUD AND ABUSE**

The Honorable Pete Stark (D., Calif.), Chairman, Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, announced today that the Subcommittee will hold a hearing on health care fraud, waste, and abuse.

This hearing will be held on Monday, March 8, 1993, beginning at 2:00 p.m., in B-318 Rayburn House Office Building.

In announcing this hearing, Chairman Stark said, "Billions of dollars each year are being drained from our health care system through fraud and abuse. We must ensure that all possible efforts are made to eliminate these massive rip-offs by unethical doctors, laboratories, and others providers."

Oral testimony will be heard from **invited witnesses only**. However, any individuals or organization may submit a written statement for consideration by the Subcommittee and for inclusion in the printed record of the hearing.

BACKGROUND:

President Clinton has focused national attention on the problem of controlling the rising costs of health care. Health care costs have escalated to more than $900 billion this year. According to a recent report by the General Accounting Office (GAO), as much as 10 percent of health care costs, or $90 billion, is lost each year because of health care fraud and abuse.

According to the GAO, "efforts to detect and prosecute health insurance improprieties are meeting with limited success." Recently the GAO released a report that examined the "rolling lab" scheme in California. This report found that over the past 10 years, the scheme resulted in $1 billion of fraudulent claims to public and private insurers.

The Office of the Inspector General (IG) of the Department of Health and Human Services is responsible for overseeing health care fraud and abuse within the Department, including Medicare. The IG estimates that for every one dollar invested in fraud detection $72 are realized in savings.

Earlier this year, the Bush Administration commissioned an "action team" to examine the problem of health care fraud and abuse. This team identified the need for legislation in several areas.

Legislation to be introduced by Chairman Stark and Congressman Levin, prior to this hearing, would establish a national health care fraud and abuse program, provide for civil monetary penalties and criminal penalties to all payers (public and private), provide intermediate sanctions on Medicare-qualified Health Maintenance Organizations (HMOs) for violations of Medicare contracting requirements, and increase funding for the IG.

(MORE)

This legislation would increase civil monetary penalty amounts to no more than $10,000 per item or service, increase the damage amount to no more than triple the amount claimed, provide for a new administrative remedy of civil monetary penalties for kickback violations, mandate either a three or five year period of exclusion for certain specified activities based on criminal convictions, and strengthen the Peer Review Organization (PRO) quality-of-care sanctions.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

For those who wish to file a written statement for the printed record of the hearing, six (6) copies are required and must be submitted by the close of business on Monday, March 22, 1993, to Janice Mays, Chief Counsel and Staff Director, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. An additional supply of statements may be furnished for distribution to the press and public if supplied to the Subcommittee office, 1114 Longworth House Office Building, before the hearing begins.

FORMATTING REQUIREMENTS:

Each statement presented for printing to the Committee by a witness, any written statement or exhibit submitted for the printed record or any written comments in response to a request for written comments must conform to the guidelines listed below. Any statement or exhibit not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All statements and any accompanying exhibits for printing must be typed in single space on legal-size paper and may not exceed a total of 10 pages.
2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.
3. Statements must contain the name and capacity in which the witness will appear or, for written comments, the name and capacity of the person submitting the statement, as well as any clients or persons, or any organization for whom the witness appears or for whom the statement is submitted.
4. A supplemental sheet must accompany each statement listing the name, full address, a telephone number where the witness or the designated representative may be reached and a topical outline or summary of the comments and recommendations in the full statement. This supplemental sheet will not be included in the printed record.

The above restrictions and limitations apply only to material being submitted for printing. Statements and exhibits or supplementary material submitted solely for distribution to the Members, the press and public during the course of a public hearing may be submitted in other forms.

* * * * *

Chairman STARK. Good afternoon.

The Health Subcommittee is meeting today to examine issues relating to health care fraud and abuse to all payers. Previously, the committee has dealt primarily with fraud and abuse in the Government-funded programs such as Medicare and Medicaid, but it has become apparent that these issues are important in the overall control of health care costs.

Health care costs have now escalated, as we have heard over and over again, to over $900 billion, and the President is focusing national attention on the problem of controlling the cost of health care. In recent polls, Americans have indicated that they believe these costs are skyrocketing because of waste, corruption, and profiteering. According to the GAO, as much as 10 percent of health care costs, or $90 billion a year is lost to health care fraud and abuse.

Most fraudulent activities involve both Government programs and private payers. Few States have as comprehensive health care fraud laws as the Medicare and Medicaid programs. Though the Federal Government does a better job than the private sector in rooting out fraud and stopping abusive practices, they could do more.

For example, the Inspector General of the Department of Health and Human Services was successful in securing nearly $7 billion in savings to the Medicare program through enforcement of existing Medicare antifraud and abuse statutes. Unfortunately, the IG has to spend money to make money and that is not happening. In 1992, the IG's budget was reduced by $6 million.

Tomorrow, I will introduce with my colleagues, Mr. Levin, Mr. Cardin, and Mr. McDermott, the National Health Care Anti-fraud Act of 1993. This bill establishes an effective national program to control fraud, waste and abuse in our health care system. The bill builds upon 25 years of Medicare experience in fighting health care fraud and abuse.

Today, we will begin to evaluate the problems of detailing and controlling fraud and abuse in both the public and private sectors. I hope today's testimony will help define these issues. I must say that I think that the Chair is not alone for anecdotal evidence. We are hearing, for instance, in home infusion therapy, of providers charging $10,000 a month for materials that cost $1,500.

And there is a hospital in Texas that sent out newsletters to their doctors regularly to encourage them to use that hospital over others, because they include a fully equipped custom Continental limo that has a television and a fully automatic bar. I don't even know what an automatic bar is. So the next time you plan a night on the town, let them help you. This letter is sent to the doctors from a particular hospital to encourage them to use that hospital.

Whether this is fraudulent or whether it is abusive, I am not sure, but I think it is the kind of thing that leads the public to think that the system needs real fixing, and I hope these hearings will be the start of seeing whether we can help with Federal legislation.

[A summary of the bill to be introduced follows:]

SUMMARY OF

NATIONAL HEALTH CARE ANTI-FRAUD AND ABUSE ACT OF 1993

H.R.____

March 8, 1993

1. All-payer Fraud and Abuse Program

The Secretary of Health and Human Services would establish and coordinate an all-payer national health care fraud control program to restrict fraud and abuse in private and public health care programs. The Secretary would be authorized to conduct investigations, audits, evaluations and inspections relating to the delivery of and payment for health care. The administration of the national program would include the coordination of the Medicare and Medicaid fraud and abuse programs.

2. Coordination With Law Enforcement Agencies and Third Party Insurers

The Secretary would be required to consult with and arrange for the sharing of data with the Attorney General, State law enforcement agencies, State Medicaid fraud and abuse units, State agencies responsible for the licensing and certification of health care providers and third party insurers.

3. Regulations Regarding All-payer Fraud and Abuse Program

The Secretary shall establish standards to carry out the program.

(a) Information standards.--All qualified health insurance plans, providers and others would be required to cooperate with the national fraud control program and to provide such information necessary for the investigation of fraud and abuse. The Secretary would establish procedures to assure the confidentiality of the information required by the national fraud and abuse program and the privacy of individuals receiving health care services. A qualified immunity would be provided to persons providing information to the Secretary under the national health care fraud and abuse program.

(b) Disclosure of ownership information.--In applying for unique provider numbers, providers would be required to disclose information that the Secretary deems appropriate, including information relating to the ownership of a health care entity.

(c) Standards related to issuance of provider identification codes.--The Secretary would be required to develop standards relating to the issuance of provider identification codes.

4. Authorization of Appropriations For Investigations and Other Personnel

The fraud and abuse staff within the Office of the Inspector General of the Department of HHS would be increased to administer the national health care fraud control program. The bill provides authorizations of $300 million in 1995, $350 million in FY 1996, $400 million in FY 1997, and $450 million in FY 1998.

5. Ensuring Access To Documentation

The Inspector General of the Department of Health and Human Services is authorized access to documentation in accordance with the Inspector General Act of 1978. Any individual or entity who fails to comply with a request of the Office of the Inspector General of the Department of HHS for records, documents and other information necessary to carry out activities under the all-payer fraud and abuse control program may be excluded from participating in Medicare and State health care programs.

6. Establishment of Anti-Fraud and Abuse Trust Fund

The bill provides that a portion of the civil money penalties, fines and damages assessed would be deposited in a trust fund. The assets of the fund would be used, in addition to such appropriated amounts, to meet the operating costs of the national health care fraud control program.

7. Application of Civil Monetary Penalties to All Payers

The provisions under the Medicare and Medicaid programs which provide for civil monetary penalties for specified fraud and abuse violations would apply to similar violations for all payers in the national health care system.

The violations would include billing for services not provided, submitting fraudulent claims for payment, hospitals giving financial incentives to physicians to reduce or limit care provided to hospital inpatients, and other violations currently included under the Medicare program.

Violations specifically tailored to the Medicare and Medicaid programs would not, however, constitute violations under the all-payer fraud and abuse control program. Such violations include overcharging under an assignment agreement and physician or supplier participation agreement, charging more than limiting charge or actual charge restrictions, and giving false or misleading information concerning hospital services which could reasonably be expected to influence a decision concerning when to discharge a patient.

8. Application of Criminal Penalties to All Payers

The provisions under the Medicare and Medicaid program which provide for criminal penalties for specified fraud and abuse violations would apply to similar violations for all payers in the national health care system. The violations would include willful submission of false information or claims, acceptance of kickbacks, bribes or rebates in return for referral for services, and other violations currently included under the Medicare program.

For providers who violate specified fraud and abuse provisions, penalties would include fines, treble damages and imprisonment. The Secretary would also identify opportunities for the satisfaction of community service obligations that a court may impose upon the conviction of an offense under this section.

Violations specifically tailored to the Medicare and Medicaid programs would not, however, constitute violations under the all-payer fraud and abuse control program. Such violations include knowingly making a false statement concerning qualifications of an institute in order that the institute qualifies for Medicare, knowingly charging for services under Medicaid in excess of rates established by the State, and knowingly and repeatedly violating the terms of assignment agreements under Medicare.

9. Amendments to All-payer Fraud and Abuse Provisions

The following revisions would apply to both the Medicare and Medicaid program and the all-payer fraud and abuse program.

(a) Civil monetary penalties.--The bill would clarify that claiming a higher code for purposes of reimbursement is prohibited and subject to civil monetary penalties. An intermediate civil monetary penalty would be established for anti-kickback violations. The current civil monetary penalty would be increased to no more than $10,000 for each item and service, and the assessment would be increased to three times the amount claimed for such items or services.

(b) Private right of enforcement.--An individual who has suffered damages as a result of a violation of the civil monetary penalty section of the Medicare and Medicaid statute would be permitted to bring an action in the U.S. District Court, if after expiration of a 60-day period the Secretary does not notify the individual that the Secretary intends to pursue a civil monetary penalty. If after one year, the Secretary has not proceeded with reasonable due diligence in investigating the matter, the individual may proceed with an action.

If the Secretary proceeds with the action, the individual may receive an amount the Secretary decides is appropriate restitution. If the Secretary does not proceed with an action, 10% of the proceeds of the action or settlement of a claim would be deposited in the anti-fraud and abuse trust fund.

(c) Criminal penalties.--The current employer-employee statutory exception would be clarified to prohibit payments to employees based on value and volume of referrals to the employer.

The United States may bring an action in an appropriate District Court of the United States, as currently provided under the civil monetary penalties section, to enjoin activity which makes a person subject to a criminal penalty and enjoin the person from concealing, removing, encumbering, or disposing of assets which may be required in order to pay a criminal penalty.

10. Amendments to Medicare Fraud and Abuse Program

The following revisions would only apply to the Medicare and Medicaid programs and would not constitute violations under the all-payer fraud and abuse program.

(a) Mandatory exclusion.--The Secretary currently has authority to exclude individuals and entities from Medicare and Medicaid based on convictions of program-related crimes and convictions relating to patient abuse. The bill would extend the Secretary's authority to felony convictions relating to fraud and felony convictions relating to controlled substance.

(b) Permissive exclusion.--The bill would extend the current permissive exclusion authority for entities controlled by a sanctioned individual to individuals with control interest in sanctioned entities.

The bill also would establish minimum periods of exclusion for certain violations already specified in the Medicare and Medicaid statute.

(c) Civil monetary penalties.--The bill would clarify that the routine waiver of Medicare Part B copayments and deductibles would be prohibited and subject to civil monetary penalties. In addition, providing items or services at less than the fair market value and retention by an excluded individual of an ownership or control interest of an entity who is participating in Medicare or Medicaid would be prohibited and subject to civil monetary penalties.

(d) Quality of care sanctions.--The bill would establish civil monetary penalties, of not more than $10,000, for each case in which the practitioner or person failed to substantially comply with the corrective action plan of the Peer Review Organization. In addition, the requirement that the provider be shown to be "unwilling or unable" to meet obligations agreed to by the provider before the Secretary may exclude the individual from participating in Medicare would be deleted.

11. Restriction on Telemarketing of Durable Medical Equipment to Medicare Beneficiaries

Suppliers would be prohibited from making unsolicited telephone contacts with beneficiaries, unless the beneficiary gives permission to the supplier, or the supplier has furnished the beneficiary with a Medicare covered item within the preceding 15 months. No payment would be made for any items furnished in violation of these provisions.

The Secretary is required to exclude from programs under the Social Security Act suppliers who knowingly make prohibited telephone contacts to such an extent that the supplier's conduct establishes a pattern of contacts in violation of the prohibition. The supplier must refund any amounts collected on a timely basis to patients or be subject to certain sanctions.

12. HMO Intermediate Sanctions Under Medicare

The Secretary would also be able to impose civil money penalties on Medicare-qualified HMOs for violations of Medicare contracting requirements.

13. Education of Medicare Beneficiaries about the Existence of Fraud and Abuse

The Secretary would notify individuals at the time of enrollment under Medicare and periodically thereafter through mailings regarding the existence of health care fraud and abuse. In addition, the Secretary would establish a mechanism for individuals to report health care fraud and abuse.

14. Publication of Sanctions Against Providers

The Secretary would be required to publish on a quarterly basis in the Federal Register a report of all final adverse actions against health care practitioners under the all-payer fraud and abuse program, including criminal convictions, exclusions from participation in Federal and State programs, civil monetary penalties and license revocations and suspensions.

15. Study on Electronic Format Process

The Secretary shall conduct a study regarding the process of providing information, in an electronic format, on ownership information required under the ownership referral provisions.

16. Administrative Provisions

(a) Uniform claims.--All claims submitted by providers would be in a uniform claims format.

(b) Unique Provider Identification Code.--Each provider would be required to submit claims using a unique provider identification code.

(c) Common coding.--Coding of procedures and diagnoses would follow uniform formats.

17. Effective Date

The amendments would apply on or after January 1, 1995.

Chairman STARK. Mr. Thomas.

Mr. THOMAS. Thank you, Mr. Chairman.

Obviously, there are no simple answers in any of these areas dealing with health care reform, and I would ask unanimous consent that my written statement be placed in the record.

Chairman STARK. Without objection.

Mr. THOMAS. Two of the greatest concerns that I have in looking at what the American people believe is wrong with the system and what professionals or experts, if you will, believe is wrong with the system, there are two areas that I think the greatest mismatch occurs. One, is in how much people believe they pay in a share of the doctor's or the hospital's bill. That is, we believe we pay 80 percent when, in fact, someone else tends to pay the 80 percent.

The other one is, and that directly relates to the hearing today, that we can solve the, quote-unquote health care problem, financing, access, and the rest, if we would just do away with waste, fraud, and abuse. There is no question that in a $900 billion system, if it is functioning—waste, fraud, and abuse, however defined—at a 10 percent level, that is a lot of money, but the problems in front of us are far greater than any solution to waste, fraud, and abuse. It is going to require a far more fundamental readjustment.

But as we go forward, it seems to me that our fundamental role, our first objective in reform, is to do no harm. Because a lot of people think they have a pretty good system right now. But after that commitment, it is to find practical realistic ways to solve real problems. Not imagined problems, not problems that someone wishes to offer you in an anecdotal fashion.

And what I am looking for today, Mr. Chairman, are some specific solutions to known fraud, waste, and abuse. Hopefully, standalone that we can plug into any system we might be able to recreate. There is no question it is out there, there is no question we want to root it out, but we have to understand that this particular aspect of the problem is there but it is not going to solve all our health care problems.

Nevertheless, people's attitude about a system is important and, therefore, I am looking forward to the testimony. Thank you, Mr. Chairman.

Chairman STARK. Thank you.

I would like to recognize the coauthor of our fraud and abuse bill, Mr. Levin.

Mr. LEVIN. Thank you, very much, Mr. Chairman. I am glad to join you and the Ranking Member here today on this important subject. This hearing is one of those that I have long felt that we should be holding regularly; that it should be part of our annual agenda, and this year, in keeping with our anticipated efforts for comprehensive reform of the health care system, we are examining, of course, fraud and abuse system wide.

I would also like to thank you, Mr. Chairman, for the work we have done together in developing the legislation that we are introducing this week. I have had a long personal interest in this issue. For example, a few years ago some cataract surgical mills were providing excessive and potentially harmful care to Medicare bene-

ficiaries in Michigan. Other members of the subcommittee have seen similar operations in their own States.

Fraud, abuse, and waste in health care consume vast amounts of vital resources every year. Illegal and inefficient practices unnecessarily increase health care charges. They also waste precious resources, which could help pay for the legitimate health care needs of the 37 million uninsured in this country, provide valuable preventive care to all our citizens, and support additional benefits for needy citizens, such as prescription drugs and long-term care. In addition, fraudulent and abusive practices can also bring physical harm to the patients who receive unnecessary services.

These statistics about health, fraud, and abuse often confuse more than clarify this issue. Let me just point out a couple of cases in Michigan in which the inspector general has brought those who abused the system to justice. For example, the case of an osteopathic physician who was convicted in Detroit on 69 of 72 counts involving Medicare fraud and illegal distribution of cocaine. He had billed for laboratory tests allegedly performed in his office, by his employee, the employee claimed to be medically necessary. None of these conditions were true.

Another case where a company submitted 837 false Medicare claims on behalf of a corporation between January 1983 and December 1984. An OIG investigation showed that the claims misrepresented patients as receiving monitoring services when they were only receiving cardiac monitoring while being treated in the emergency room.

These are not typical health care providers, clearly, but they are examples of the good work the IG office has done. However, I am worried, because the Office of the Inspector General has such limited resources in relationship to the trust fund and tax dollars involved, that we are going to be shortchanged in these efforts to get at fraud and abuse.

The OIG's fiscal year budget for 1993 is $101 million. This goes not just for the protection of Medicare but also for Medicaid, Social Security, and all the other functions of the Department of Health and Human Services across 50 States.

We are now focusing on national reforms to the health care system. We cannot adequately control costs, expand access, or afford to implement these much-needed systemic reforms without providing effective fraud and abuse weapons for both private and public payers. And that is why we are introducing the National Health Care Anti-fraud and Abuse Act of 1993, this year.

I am glad the American Medical Association could be here today because I believe the vast majority of physicians and all health care providers are honest. In addition, in testimony submitted for a hearing to this subcommittee last September, the AMA noted, in quotes, efforts need to be undertaken to identify and eliminate abusive, wasteful, and fraudulent activities.

I look forward to our discussion with today's distinguished witnesses, Mr. Chairman, and I welcome, as you do, and Mr. Thomas, their advice as well as their recommendations as we work on this vital issue in the coming months.

Chairman STARK. Thank you, Sandy.

[The prepared opening statement of Mr. Levin follows:]

SANDER M. LEVIN
17TH DISTRICT, MICHIGAN

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OPENING STATEMENT BY REP. SANDER LEVIN

House Ways and Means Health Subcommittee

March 8, 1993

Thank you Mr. Chairman for holding this hearing on the issues surrounding all-payer health care fraud and abuse. I have long believed that hearings on this general issue should be part of the Subcommittee's annual agenda. This year, in keeping with our anticipated efforts for comprehensive reform of the health care system, we are examining fraud and abuse system-wide.

I would also like to thank the Chairman for the work we have done together in developing the legislation we introduced today. I have had a long personal interest in this issue. A few years ago some cataract surgical mills were providing excessive and potentially harmful care to Medicare beneficiaries in Michigan. Other members of the Subcommittee have seen similar operations in their own states.

Fraud, abuse and waste in health care consume vast amounts of vital resources every year. According to General Accounting Office, health care fraud was an $80 billion problem in 1992. Consumer Reports estimates that abuses of the system by providers and others in the form of clearly unnecessary tests and procedures may add $130 billion to the cost of health care. Simple waste adds billions more. Exact calculations of this figure are difficult at best, but a rough guide is that with the current patch-work of insurers and payers, fraud and abuse consumes about 10% of national health spending.

These illegal and inefficient practices unnecessarily increase health care charges. They also waste precious resources, which could help pay for the legitimate health care needs of the 37 million uninsured in this country, provide valuable preventive care to all our citizens, and support additional benefits for needy Seniors, such as prescription drugs and long-term care. In addition, fraudulent and abusive practices can also bring physical harm to the patients who receive unnecessary services. Often our most vulnerable citizens, the elderly and the sick, are the very targets of fraudulent operators.

The statistics about health fraud and abuse often confuse more than clarify this issue. Let me just point out a couple of cases in Michigan in which the Inspector General has brought those who abused the system to justice:

- Calvin Price, an osteopath, was convicted in Detroit on 69 of 72 counts involving Medicare fraud and illegal distribution of cocaine. He had billed for laboratory tests allegedly performed in his office, by his employee, and claimed to be medically necessary. None of these conditions were true. The judge revoked Price's bond and immediately remanded him to jail until his sentencing. The fraud investigation was conducted by the Office of the Inspector General, and the drug investigation was conducted by the Federal Bureau of Investigation and the Michigan State Police.

- Maraveleas Associates, Inc., has been sentenced in Michigan for submitting 837 false Medicare claims on behalf of Ingham Emergency Physicians, P.C., between January 1983 and December 1984. An OIG investigation showed that the claims misrepresented patients as receiving holter monitoring services when they only received cardiac monitoring while being treated in the emergency room. Maraveleas must pay the maximum fine of $10,000, restitution of $67,375, and a civil monetary penalty of $132,625. The company was also excluded from the Medicare, Medicaid, and block grant programs.

Clearly these are not typical health care providers, but they are examples of the good work the Inspector General's Office has done. However, I am worried, because the Inspector General's Office has such limited resources in relation to the trust fund and tax dollars involved. The Inspector General's Fiscal Year 1993 budget is $101.8 million. This goes not just for the protection of Medicare, but also for Medicaid, Social Security, and all the other functions of the Department of Health and Human Services across all 50 states. In addition, these funds are not solely for investigations. They must support the OIG function of audits and evaluations, as well as investigations. I realize we have a tremendous problem with the deficit, and must watch every dollar of spending, but there are instances where we need to spend money in order to save money and safeguard the public's trust. This is one of those areas.

While we have done much in Medicare to combat fraud and abuse, I remain concerned about private health insurers' efforts to attack these problems. They do not have the same legal and administrative tools to effectively combat fraud and abuse.

We are now focusing on national reforms to the health care system. We cannot adequately control costs, expand access, or afford to implement these much-needed systemic reforms without providing effective fraud and abuse weapons for both private and public payers. That is why I will be introducing, with the Chairman of the Subcommittee, the "National Health Care Anti-Fraud and Abuse Act of 1993." This bill builds upon our past legislative initiatives and creates a seamless nation-wide program for eliminating fraud and abuse. There are a few specific about this legislation which I would like to highlight:

1) It includes provisions for simplifying the paperwork for health care bills. These will not only increase the ability to track health care transactions, but also reduce the hassle factor for physicians and other providers.
2) Through an all-payer program, there will be coordination not only among payers, but with all law enforcement entities nationwide.
3) The authorization for the Office of the Inspector General will be substantially increased.
4) The Secretary will educate Medicare beneficiaries about health care fraud and about how to report it.
5) The civil and criminal penalties already in law for certain types of Medicare fraud will be increased, and these civil and criminal penalties available for Medicare will be extended to all payers.
6) The circumstances which allow the Secretary to exclude individuals from the Medicare program will be clarified and expanded.
7) All individuals who are sanctioned or convicted under the Medicare laws for fraud will be published quarterly in the Federal Register. This will provide a single source for this information.
8) Unsolicited telephone solicitation will be restricted.

I am glad that the American Medical Association could be here today because I strongly believe that the vast majority of physicians and all health care providers are honest. In addition, in testimony submitted for a hearing this Subcommittee held last September 10th, the AMA noted that "efforts need to be undertaken to identify and eliminate abusive, wasteful and fraudulent activities." The AMA supported the findings of the GAO report which called for establishing comprehensive solutions to health fraud and abuse. In addition, I have noted their promotional efforts to combat fraud and abuse.

I look forward to our discussion with today's distinguished witnesses, and I welcome their advice as well as recommendations from other interested parties as we work in the coming months.

Chairman STARK. We will begin our testimony today with testimony from the General Accounting Office, who is represented by Janet Shikles, the Director of Health Financing and Policy Issues. She is accompanied by Ed Stropko, the Assistant Director.

As with all of the witnesses today, and with the opening remarks, they will appear in the record in their entirety, and we would ask the witnesses if they would care to summarize or expand on their written testimony in any manner they desire.

Welcome back, Janet. Proceed

STATEMENT OF JANET L. SHIKLES, DIRECTOR, HEALTH FINANCING AND POLICY ISSUES, HUMAN RESOURCES DIVISION, U.S. GENERAL ACCOUNTING OFFICE, ACCOMPANIED BY ED STROPKO, ASSISTANT DIRECTOR

Ms. SHIKLES. Thank you.

Mr. Chairman and members of the subcommittee, I appreciate the opportunity to testify today on health care fraud and abuse and the need for better remedies and more resources to combat the problem.

Health care fraud and abuse encompass a wide range of improper billing practices that include overcharging for services provided, charging for services that were not provided, accepting bribes or kickbacks for referring patients, and providing inappropriate or unnecessary services. Of particular concern is that health care fraud has moved beyond a single activity to organized health care programs affecting both the Government and private insurance sectors.

For example, one fraudulent scheme that has troubled public and private payers in California for the past decade is alleged to have involved over $1 billion in fraudulent billings from about 90 percent of all the insurers in California and involved about 200 physicians and other providers. The scheme centered around soliciting people with health insurance who go to mobile labs, called rolling labs, for noninvasive tests such as heart and blood pressure measurements. Frequently, the laboratories and the referring physicians then used phony diagnoses in submitting the insurance claims.

What is troubling is that thus far the outcome of this scheme is owners have been both sued and prosecuted successfully yet virtually no moneys have been recovered. Also, at least six similar schemes are known to be operating in Southern California.

We have identified several obstacles that help to explain how the rolling lab scheme, and other schemes like this, are able to continue to prosper for so long. First, we have over a thousand payers currently processing about 4 billion claims a year, paying hundreds of thousands of providers and they all use different payment methods and billing regulations.

Second, providers' claims are paid by many insurers, making billing patterns very hard to identify. Thus, a provider who bills for more services than can normally be provided in a single day might not be discovered when claims are split among many insurers.

Third, sharing data among individual insurers for the purpose of detailing suspicious billing practices is currently very difficult. This is because laws protect the privacy of patient records and the data collected on insurance claims are quantitatively and qualitatively different for each insurer.

Fourth, many freestanding or nonhospital facility which perform such procedures as diagnostic testing or pain management or operate like the rolling labs are not licensed in many States and are, therefore, difficult to monitor. Insurers are limited in their ability to trace and hold accountable the source of fraudulent billings in these unlicensed medical facilities.

Now, while these obstacles help to explain the difficulty in preventing are detailing fraudulent or abusive billing practices, insurers also encounter problems in prosecuting health insurance fraud. For one, successful prosecutions may take years, involve an investment of considerable staff time and financial resources, and may not result in insurers recovering their money.

Also, the nature of certain laws can also impede private insurers' efforts to pursue fraud. For example, some States lack antikickback statutes that prohibit physicians from profiting from referrals. Others have statutes so broadly written that there is much debate surrounding their use and, therefore, are reluctant to enforce them.

Finally, in some jurisdictions Federal prosecutors may not accept criminal health care cases because they are so overloaded so they can only accept cases involving $100,000 or more.

Last spring, we recommended that Congress consider establishing a commission to develop recommendations to address some of the problems that make it difficult for insurers to detail and pursue health care fraud and abuse. In January, OMB, the Attorney General and the Department of Health and Human Services released a report on health care fraud and abuse that contains recommendations on many of these same issues.

We believe that congressional consideration of these recommendations, coupled with adequate support for the Federal agencies charged with investigating and prosecuting fraud and abuse, such as the Office of the Inspector General, would go a long way toward reducing the impact fraudulent and abusive practices are currently having on health care costs.

Mr. Chairman, this concludes my statement, and I would be happy to take any questions.

Chairman STARK. Thank you.

[The prepared statement follows:]

STATEMENT OF JANET L. SHIKLES, DIRECTOR, HEALTH FINANCING AND POLICY ISSUES, HUMAN RESOURCES DIVISION, U.S. GENERAL ACCOUNTING OFFICE

Mr. Chairman and Members of the Subcommittee:

I appreciate the opportunity to testify today on health care fraud and abuse and the need for better remedies and more resources to combat the problem. Recently we reported on such federal programs as Medicare that are at risk of substantial losses to waste, fraud, and abuse.[1] We have also, over the past year, issued several other reports addressing aspects of health care fraud and abuse. Briefly, our work has shown that all health care payers are vulnerable to fraud and abuse and that significant obstacles hinder the prevention of dishonest billing practices and the pursuit of health care profiteers.

To discuss these issues in greater detail, I will address the size and nature of health insurance fraud and abuse, and review the obstacles that frustrate efforts to detect and investigate health care fraud cases.

SIZE AND NATURE OF HEALTH INSURANCE FRAUD AND ABUSE

In our work we cite an estimate made by health industry experts that fraud and abuse add some 10 percent to U.S. health care's costs,[2] which currently exceed $800 billion. Because of the hidden nature of fraudulent and abusive practices, however, the exact magnitude of the problem cannot be determined.

Fraud and abuse encompass a wide range of improper billing practices that include overcharging for services provided, charging for services not rendered, accepting bribes or kickbacks for referring patients, and rendering inappropriate or unnecessary services. Both fraud and abuse result in unnecessary costs to the insurer, but fraud generally involves a willful act.

As a practical matter, whether and how insurers pursue a wrongful act can depend on the size of the financial loss incurred and the quality of the evidence establishing intent. For example, small claims are generally not pursued as fraud because of the cost involved in investigation and prosecution.

Health care fraud has expanded beyond single health care provider fraud to organized activity affecting health care programs in both the government and private insurance sectors. For example, one fraudulent scheme that has troubled public and private payers in California over the past decade is alleged to have involved over $1 billion in fraudulent billings from as many as 200 physicians and other providers. The scheme centered around soliciting people with health insurance to go to mobile labs, called "rolling labs," for noninvasive tests, such as heart and blood-pressure measurements. Frequently, the laboratories and the referring physicians used phony diagnoses in submitting the insurance claims.

Thus far, the outcome of this scheme is that the owners have been both sued and prosecuted successfully, yet virtually no monies have been recovered. Also, at least six similar schemes are known to be operating in southern California. Schemes of this nature highlight several serious problems facing public and private payers. First, large financial losses to the health care system can occur as a result of even a single scheme. Second, fraudulent providers can bill insurers with relative ease. Third, efforts to prosecute and recover losses from those involved in the schemes are

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[1]Medicare Claims (GAO/HR-93-6, December 1992) and Government Management--Report on 17 High-Risk Areas (GAO/T-OCG-93-2, Jan. 8, 1993).

[2]Health Insurance: Vulnerable Payers Lose Billions to Fraud and Abuse (GAO/HRD-92-69, May 7, 1992).

costly. Finally, schemes can be quickly replicated throughout the health care system.

Losses to fraud and abuse stem from several problems that do not fall into mutually exclusive categories, but in general include the following:

-- Health insurers operate independently and are constrained legally and administratively from collaborating on efforts to pursue fraudulent providers. Ultimately, even when fraudulent providers get caught by one insurer, they can continue billing other insurers.

-- Criminal prosecution and civil pursuit of fraud is expensive, slow, and has been shown to have little chance of recovering financial losses. Moreover, private insurers are largely without access to the administrative remedies of the public payers, such as the ability to exclude providers convicted of health care fraud from billing the public programs.

-- Insurance and law enforcement resources are not sufficient to detect and pursue much of the health care fraud.

HEALTH INSURANCE SYSTEM HIGHLY VULNERABLE TO FRAUD AND ABUSE

Now I would like to explore a few characteristics of the environment in which the billion-dollar rolling-labs scheme was able to flourish.

-- First, over a thousand payers process 4 billion claims a year to pay hundreds of thousands of providers using different payment methods and billing regulations.

-- Second, providers' claims are paid by many insurers, making billing patterns hard to identify. Thus, a provider who bills for more services than can normally be provided in a single day might not be discovered when claims are split among many insurers.

-- Third, sharing data among autonomous insurers for the purpose of detecting aberrant billing patterns is largely not feasible for two reasons. First, laws protect the privacy of patients' medical records. And second, the data collected on insurance claims are quantitatively and qualitatively different for each insurer.

Additional factors hamper efforts to develop a case against a provider suspected of health care fraud. For example, many "freestanding," or nonhospital, facilities, which perform such procedures as diagnostic testing and pain management, are not licensed in many states and are therefore more difficult to monitor. Insurers are limited in their ability to trace and hold accountable the source of fraudulent billings in these unlicensed medical facilities. Also, physicians frequently invest in medical facilities and are not always required to disclose their investment in facilities to which they refer patients. Insurers, however, have no systematic way of monitoring referral patterns.

Finally, prosecuting health insurance fraud entails another set of problems:

-- Successful prosecutions may take years, involve an investment of considerable staff time and financial resources, and may not result in insurers recovering their money.

-- The nature of certain laws can impede private insurers' efforts to pursue fraud. For example, some states lack

anti-kickback statutes that prohibit physicians from profiting from referrals. Furthermore, the language of anti-kickback statutes is so broadly written that in states with these laws there is much debate surrounding their use and therefore a reluctance to enforce them.

-- In some jurisdictions, federal prosecutors may not accept criminal health care cases involving less than $100,000 because of limited resources.

Diverse and autonomous insurers have few established means of collaborating systematically to solve these problems. In our view, if the efforts of independent payers, public payers, and state insurance and licensing agencies, as well as state and federal law enforcement agencies, were more coordinated, the attack on health care fraud and abuse would be more fruitful.

In 1992, we asked the Congress to consider establishing a national health care fraud commission to develop recommendations on such issues as

-- greater standardization of claims,

-- mechanisms to allow for the exchange of information among insurers and others without undermining privacy and antitrust concerns,

-- the need for greater regulation of nonhospital facilities, and

-- model state statutes covering kickbacks and other fraudulent practices.

More recently, a federal task force consisting of the Secretary of Health and Human Services, the Director of the Office of Management and Budget, and the Attorney General has made recommendations addressing many of these same health care fraud and abuse issues.

RESOURCE CONSTRAINTS HAMPER INVESTIGATIONS AND PROSECUTIONS

Resource constraints also add to the problems of pursuing health insurance fraud. A single large fraud case can consume significant investigative and prosecutorial resources, leaving other cases unpursued. For example, in the case of the rolling labs scheme, California state investigators told us that similar schemes allegedly operating in the same geographic area were not likely to be investigated or prosecuted until the rolling labs case had gone to trial.

The lack of investigative resources has constrained two federal agencies significantly involved in pursuing health care fraud--the Department of Justice and the Office of the Inspector General in the Department of Health and Human Services (HHS).

At least until recently, Department of Justice efforts to combat health insurance fraud have been adversely affected by resource constraints. Recognizing the need for additional resources to address health care fraud, the Federal Bureau of Investigation reassigned 50 agents from other areas to health care. This means that a total of 150 agents nationwide will be devoted to health care cases. At the same time, the Department of Justice assigned 10 new positions to enforce a health care fraud initiative and formed a health care fraud unit within its criminal division.

The HHS Inspector General continues to cite resource limitations as a major impediment to investigating and pursuing many types of fraud and abuse. For example, the number of Inspector General investigators has declined during the last 5 years, though the Inspector General's statutory responsibilities,

and the size and complexity of the federal programs that the Inspector General investigates has increased significantly. What this means is that in many localities the Inspector General has few people to investigate health insurance fraud. For example, until recently, the Inspector General had less than two full-time people working on health fraud in southern California, where rolling-labs schemes have been prevalent.

Such investigative resource limitations can discourage Medicare claims processors--involving some 80 contractors across the country--from developing cases to refer for further action. That is, the contractors depend on the Inspector General to pursue fraud cases, and when contractors anticipate that few cases will be accepted for further investigation, they have little incentive to develop any but the most egregious cases for referral.

CONCLUDING OBSERVATIONS

Only a fraction of the fraud and abuse committed against the health care system is identified and prosecuted and that which has been detected has involved substantial sums. Without adequate resources, investigation and pursuit of much of the health care fraud is not possible. Currently, dishonest providers can continue operating, in part, because of the lack of staff and money dedicated to pursuing them.

However, added resources alone will not succeed in overcoming fraud and abuse in the health insurance industry. We believe that the efforts of independent private payers, public payers, and state insurance and licensing agencies as well as state and federal law enforcement agencies need to be better coordinated. This would facilitate overcoming the systemic obstacles that hamper efforts to address health care fraud.

* * * *

Mr. Chairman, this concludes my testimony. I'd be pleased to answer any questions.

Chairman STARK. I stated earlier that I thought that Medicare did a better job than the private sector, I am going to rephrase that and, basically, I think the private sector hardly does anything at all, for several reasons:

As you indicated, the private insurance companies, in order to recover an occasional bill of $100 or $200, might have to spend tens or hundreds of thousands of dollars to investigate it and they don't have the laws to put the people out of business, so there is not very much of a risk-reward for them. Many States don't have any laws at all that cover it.

Am I missing something there in what I have said? Does Medicare do a better job? Is there another structure? Could this all be turned over to a model State law and turned over to district attorneys? Do they have the training? What are some of the reasons that we should use this model that we have, which is probably the only one in the country, just because it is there? Is there, in fact, a better alternative or reasons that you have not covered for using it as a model?

Ms. SHIKLES. Well, private insurers are definitely having a much more difficult time going after this issue than the Medicare and Medicaid programs. In the rolling labs case, Aetna spent, I think, about $1 million. They got an $18 million judgment and they still have not received any money. So cost is a real deterrent for private insurers. It is expensive to go after fraudulent providers and insurers and have no guarantee they are going to get any return.

Medicare is able to do a better job than the private insurers just because they have certain resources available to them that the private insurers don't have. They have actions that they can take with the inspector general's office that are not available to private insurers. So certainly you are right, that Medicare is able to be more aggressive than the private insurers, although they are trying to do their part, too.

We feel that Medicare is not doing enough; we also feel that—and everyone that we have talked to believes it has to be a concerted action; that you have to take the States and the private insurers, the providers, the public payers, not just Medicare and Medicaid, and they need to work together to figure out what is a good way to address this issue without violating individual rights.

Chairman STARK. The other issue that will come up, I think, is that this is just fine for us to do relative to the spending of Federal dollars. I would guess we are spending $250 billion in Federal dollars out of the $900 billion spent. So that you have $650 billion out there that is all private money. Some people might ask why should we be controlling that—that is just private sellers and private buyers and it is a buyer beware.

Is this something that is broad enough that you think that there is a Federal interest here so that we should extend it to all payers? We will be criticized on that, and I think it is something we should establish the need for.

Ms. SHIKLES. It is a very broad problem and I think the private insurers will tell you that they need help and Medicare and Medicaid need help, too. Because what you have, the same small number of fraudulent providers who are taking advantage of the fact that our public and private payers cannot work together, and they are

ripping off all of us. If Medicare or Medicaid catches them, they just move on to Aetna or CIGNA. Because we don't have a coordinated strategy they can then continue to steal from our health care systems.

Ultimately, the taxpayer is the one who then bears the increased cost. So it is a systemwide problem.

Chairman STARK. Thank you very much. Mr. Levin. I am sorry, Mr. Thomas, you were here first.

Mr. THOMAS. There are so few of us, we may have a couple of rounds of questions.

You are describing insurance fraud and it happens to be in the medical area. I assume that some of the problems you outlined, in terms of the way in which health insurance is offered, the confusing forms, the multiple billings and the rest, creates the opportunity for it. Do we have any parallels in other insurance areas that have been offered?

Do we have it with automobile insurance injury claims or other kinds of insurance frauds or is it pretty much uniquely at this level in the health area?

Ms. SHIKLES. Well, we have not studied specifically the other insurance areas, and so I really cannot answer that question. What I can tell you, though, is that this is an area—I did mention that one reason that this can exist is because we have so many different forms and different——

Mr. THOMAS. We are hopeful in cleaning up the insurance area that we can solve that problem.

Ms. SHIKLES. That is what I was going to say. That really is an issue that Secretary Sullivan took leadership on, set up a committee toward standardization, so I think that is one area we can move forward in.

Mr. THOMAS. We are hopeful the task force and the private insurance industry has indicated to me that they are very anxious to move in that common form, open communication structure. That will help out a lot.

What about the penalties? Do you find we have adequate tools? I know for example in the drug seizure area, for a long time we were not as effective as we wanted to be because of the dollars and cents involved, you can arrest people, you can fine them, you can put them in jail, but unless you seize the property or pull credentials of some sort in an attempt to stop them from continuing that activity, do you feel that you have adequate tools available? Are there the tools available for the law enforcement now or do you need additional?

Ms. SHIKLES. Well, we focused more on the fact—we do know we need additional resources at the inspector general's office and at the FBI, and they have been trying to put more resources into health care fraud investigations.

In terms of whether the penalties are tough enough and asset forfeiture laws and those types of things, I think it would be more appropriate to ask the inspector general who really focuses on that side of the fraud issue.

Mr. THOMAS. Well, we will. And do you feel that there can be better communication on the Government's side between the inspector general, when they decide to go civil with the Justice Department,

if and when they decide to go criminal, are we, in fact, hampered because we don't have the kind of communication and structure? I know one of the reasons for the evolution of the FBI, obviously, in the early 20th Century was the criminals were more high-tech than law enforcement at that time. They did not have the ability to cross State lines, communicate and work closely together, and one of the reasons we became very successful or more successful than we had been was because of Government coordination.

Do we need to look at that as well? The chairman mentioned State and Federal coordination, along with local as well.

Ms. SHIKLES. Yes, I think we do. We need to find ways so that we can better coordinate. But, again, we would want to include the private sector and the State offices as well, because every scheme that you look at, that small sector of fraudulent providers are operating across the board. If we find them in Medicare, we know they are also billing private insurers.

Mr. THOMAS. You will find the chairman has his vision of tomorrow in the health care area in which the private sector is greatly diminished and the problem would then be reduced. He is not anxious to see the private sector heavily involved.

My problem, though, fundamentally, goes to one of the two points I mentioned earlier, about the individuals themselves, the consumers themselves. They are not knowledgeable about how much they actually pay in a proportional amount for health care. And it seems to me, we are dealing a little bit with a public that is not as educated as much as they could be in what the assumables are and the way in which they can assume them in the health care area.

An informed public, I think, is almost always our best bulwark against con games of any kind, including those in the health care area. Yes, we can spend more dollars; we can put more people on the streets and do more investigation, but don't you think that hand-in-hand, it will be a failure if we try to restructure it and we don't include the significant component of consumer education about all aspects of health care and their role in not only keeping it honest, but in making judgments about choices, because they always have behavioral consequences?

Ms. SHIKLES. I think that is a critical role that needs to be included and is just as important as some of the other things we think need to be done.

Mr. THOMAS. Thank you, very much, Mr. Chairman.

Chairman STARK. Mr. Levin.

Mr. LEVIN. Thank you.

Welcome.

I gather if one needed to summarize your testimony, it would read something like, a small number of people are ripping us off big; is that correct?

Ms. SHIKLES. Yes, that is correct.

Mr. LEVIN. And there is no doubt that the rip-off is big?

Ms. SHIKLES. There is no doubt.

Mr. LEVIN. As you say, the exact amount cannot be estimated; some have said it is 10 percent. Would you be surprised from your inquiries if it were at least 5 percent of the total that is spent on health care?

Ms. SHIKLES. No, I wouldn't be surprised.

Mr. LEVIN. You would not be. That would be $40 billion; wouldn't it?

Ms. SHIKLES. I think it is a very significant problem.

Mr. LEVIN. Let me, because I very much agree with Mr. Thomas about an educated consumer. I think your testimony is that we need to do much more educating of the consumer, but there are also some things that government can do, local, State, and Federal, in its structures.

Ms. SHIKLES. That is right.

Mr. LEVIN. So we have just a few minutes, but give us a few examples, for example, let's try to be somewhat concrete. In terms of coordination, for example, do you think it is possible for us to devise methods so that there would be better coordination between the public and private sectors?

Ms. SHIKLES. Yes, I do. It depends on how you want to set that up, but I don't think that would be a problem because there is pretty much agreement across the key players, the physicians, the different providers, State insurance offices, the different law enforcement authorities that this is a problem; that we need to make some changes to try to reduce the amount of abuse in the system, and then where you just need to get agreement is on the kinds of things you want done.

But it is pretty straightforward. You need to have some standardization of the claims system, which insurers agree they want to move forward on; we need one billing number nationally, because what you find in a lot of scams is they use many—sometimes hundreds of—different billing numbers.

Well, there is no insurance system, no matter how sophisticated it is, that can detect they are billings by, really, one physician, if they are using all these different billing numbers. So we would like one billing number.

This group would also need to focus on what background providers need to start billing an insurer. Right now an insurer, particularly on the private side, almost has to pay anyone who bills them, and then if you find out later that they are crooked, you go after them and it is really only a post office box. So you would like to have some agreement on what criteria should be involved for somebody who is not licensed in the State but is going to bill an insurer.

Mr. LEVIN. So there are some concrete things. For example, the bill we will be introducing this week provides for that single number we are talking about, so providers don't have lots of numbers that they just use. That is a real problem; isn't it?

Ms. SHIKLES. It is a real problem.

Mr. LEVIN. We can resolve it. We don't need a commission, or we don't need——

Ms. SHIKLES. Right, it is a real problem and solving it would not in any way impact on the majority of providers who are honest. But it does allow your information systems to pickup and get rid of the fraudulent provider who is able to operate under the cover of numerous different billing numbers.

So there is a set of concrete activities that I think there is a lot of agreement on, that you could move forward, that would make it difficult to abuse the health care system.

Mr. LEVIN. Also, you refer to the differences in laws among jurisdictions, and some States don't have antikickback laws at all. I mean we can, can we not, in the bill we are introducing, create an integrated web of laws?

Ms. SHIKLES. That would be extremely helpful, because kickbacks are part of just about every scam you look at across the health care provider community where there is fraud involved. And so if you can at least make that illegal and make it uniform, that would be helpful to insurers and law enforcement officials.

Mr. LEVIN. One last point. You mention in your testimony, and we will be talking more about it later, about the reduction in the numbers available in the inspector general's office. You say, for example on page 8, the numbers of IG investigators has declined during the last 5 years.

I know you want to be cautious about this, but does that really make any sense when we have fraud, abuse that may eat up as much as 10 percent of $800 billion?

Ms. SHIKLES. We think it makes no sense. We are very worried about it, because the inspector general is seeing an increasingly complex set of requirements. Health care fraud is becoming much more sophisticated, particularly with using computers, you are able to rip off a lot of money very quickly. And if you are going to toughen the rules and the laws, on the one hand, you are still always going to have a group of people who are going to be a step ahead of you and you have to have a strong inspector general's office to be able to make that group pay.

Mr. LEVIN. Your testimony is most welcome. It is time to get tough on fraud and abuse in the health system, and you have helped to point the way.

We appreciate your testimony.

Ms. SHIKLES. Thank you.

Chairman STARK. Mrs. Johnson.

Mrs. JOHNSON. Thank you, and welcome.

This is an important subject. The issue of resources, I think, is an important one, but it is also true that we have let the resources decline during the very years when the evidence of fraud has been clearest and growing most rapidly and when the need to cut spending in Medicare became most acute.

So we have not been able to do it, not because this committee was not committed, but because the appropriations process had other priorities. So I think it is unrealistic to look at the kind of investment in resources that we really need to control this problem.

So I think it does matter a lot what laws we pass and what regulations we adopt to implement some of the proposals that you have made, which I concur with.

If we have a moment, I want to get to the work of the commission that was established last year, that was to focus on these things that you mentioned briefly toward the end of your testimony but didn't in your oral testimony. But before I get to that, because I think it is more important, it struck me in reading through your testimony last night that the real answer is managed care. Because if the only way you can get reimbursed for care is if you got that care as part of a system of care, an organized system of care, you are going to knock out billing by these freestanding nonhospital fa-

cilities, because they will, unless they are part of a network, they will not be reimbursable.

If they are part of a network, there will be a single billing and the number of reimbursers and the variety of claims will automatically be reduced, particularly if we build the network properly with a foundation in place for uniformity and center it on that sort of basic benefit plan which all of us are talking about.

But it is very impressive how a network of care, that approach to providing care, could allow you to identify patterns far earlier, could allow you to reduce the number of payers, the number of providers, and streamline and simplify the entire reimbursement system. It would circumvent some of the data-sharing issues that are difficult and are holding us back. And, most importantly, it would allow us to get directly at fraud in a way we won't if we rely on increasing resources, and in a way that we cannot, given our judicial system, which does simply drag out the time it takes and increase the cost of litigation so much that we end up watching scams continue at the very time we know that they are, in fact, scams costing taxpayer dollars.

So I did want to point out the relationship between the kind of managed-competition vision that some of us have and the fraud and control possibilities that such a far greater controlled system of providing health care would make available, make possible for us. Then I would like you to comment on the work of the commission that began work on these very issues, the single number, the standardization of forms, and so on, that the Secretary of HHS, the Director of OMB, the Attorney General, and some others; where are they in their work and what do you think of their work?

Ms. SHIKLES. Well, I think it is excellent, and they released a report just 2 months ago.

Mrs. JOHNSON. What recommendations did it have that you would support?

Ms. SHIKLES. We would support the fact that they would extend the antikickback rules that are now operable in Medicare and Medicaid, to all payers; they would extend the ban of self-referral to all payers and then broaden it beyond laboratories. Both of those would be excellent things to do because almost every scheme that you look at has those ingredients in them.

They would also set up two data systems, what Congressman Thomas asked about. One would be final cases, once they were completed, a national system that I think private and public payers would have access to, and then they would set up a system of ongoing cases, and you would have to look at that very carefully to make sure there was confidentiality and rights were protected. But one of the current problems in our system is that you could have somebody operating against one insurer and they are also operating against other payers but the other payers don't know about it.

If one person gets tipped off, it may be 2 years later before someone else picks it up. There needs to be a way that people can learn about this. The task force report that was issued in January, recommends a national group, that would have information on ongoing cases that could be useful.

Mrs. JOHNSON. I think that is important because it shows how broadly bipartisan this issue is and how broadly bipartisan the so-

lutions are. We have the information, I do hope we can act this year but, as I say, I hope as part of the kind of reform we adopt to change the way we deliver health care services, we will recognize that ultimately that is the solution.

Thank you, Janet.

Chairman STARK. Mr. McDermott.

Mr. MCDERMOTT. Thank you, Mr. Chairman.

I listen to this and wonder, what are the data bases to get the information that one would need to do a thorough fraud and abuse program; what do you have out there now nationally?

Ms. SHIKLES. Well, you really don't have the kind of national data base that you would need. What you have are private insurers operating independently and they really cannot share their information with other insurers.

Mr. MCDERMOTT. There is no way to access the files to see if a physician is billing in multiple systems for the same service?

Ms. SHIKLES. In some States they have tried to pass laws to encourage that kind of sharing, and the national antifraud association that you are going to hear from later this morning, I know has really been encouraging that sharing of information so we could have a coordinated attack on fraud and abuse. But, in general, I believe, that insurers are very reluctant to provide this kind of information. And with good cause; they are afraid of violating privacy rights, they are afraid of being sued by providers. They have no protection.

The other problem is that our insurance systems, they are hard to match because we are all using different forms, different regulations. Now, that is one area we are moving on, and as we move toward more standardization, you would be able to share information. But you need a committee or some group has to, or you have to pass a law that will allow these insurers to provide this information to some group, and that if they provide this information, they will be protected from being sued.

Mr. MCDERMOTT. You gave one example of why an insurance company might not think it was in its best interest to do something about fraud now; that is, it might spend a lot of time and money in court and ultimately wind up with a judgment 10 years later, but no actual collection. Are there any other reasons you can think of that it just doesn't work under the present system?

Essentially what you are saying is that, the present system is so cumbersome there is no point for an insurance company to get involved.

Is there any other reason you can think of?

Ms. SHIKLES. Well, the major reason in addition to that is that you have these different insurance companies and they only have a piece of the whole system, and they could put a lot of resources and maybe not be able to pickup the significant problems. Because these fraudulent providers are very clever and they can figure out if you split your bills across different insurers, you can do a lot of things, and it is very difficult for insurers to pickup that this same doctor is double billing them, billing Aetna, billing CIGNA, billing Medicare. And if we cannot collaborate and at least figure this out, it is hard to really solve the problem and stop the fraudulent providers.

So there is all kinds of disincentives for a private insurer to try to take this issue on. They are trying to take it on, but there is not a lot of payback. They do get cases, but they know a lot more is going on.

It is also very expensive for them. So if they could collaborate, put their resources in with other commercial insurers, Medicare, Medicaid, you would have more of a payback for their customers.

Mr. MCDERMOTT. It sounds, from listening to you, like you are arguing really for a unitary system, a single system in which everybody is recording data under the same form, and payment is made through one source; isn't that the most efficient way to catch fraud and abuse, through a single system?

Ms. SHIKLES. I don't know if that is the most efficient way. I am arguing that there are changes that we can make to our current system that I think could be made pretty quickly, that there is a lot of agreement on, that could certainly reduce a significant amount of abuse and fraud that is going on now.

Mr. MCDERMOTT. It sounds to me that a single-payer system that has a national data base is the most likely way that you are going to be able to stop what is going on. As long as you have 1,500 insurance companies all doing different things, even if they have the same form, if they are not all in the same information system and being paid in the same way, you will still have the capacity for people to figure out ways to go around the system.

Ms. SHIKLES. Yes, but you have what you are describing in the Medicare program, and we certainly have our share of problems with fraud and abuse. We do have more standardization in the Medicare program. But it is very difficult to keep up with fraud. If somebody wants to rip off a system, they always seem to be a couple steps ahead of you.

Mr. MCDERMOTT. But you have different fiscal intermediaries across the country.

Ms. SHIKLES. That is right.

Mr. MCDERMOTT. And all variations. So I am really saying a single system is the only way that you will have any chance, of controlling this problem . Even in Medicare, where we do better than the private sector and where we have the incentive of being at-risk, we don't do very well at this point, and I think that is why a single-payer system with a national data base is the only way we will get it.

Thank you.

Chairman STARK. Mr. Thomas.

Mr. THOMAS. Just briefly.

I have found that fraud flourishes for several reasons, and just because you had a central collector of information and that central collector was Government, doesn't necessarily mean that you are going to be able to detect the fraud to expose it, and then, therefore, hopefully, to do away with it.

And I think, Ms. Shikles, that is why you were reluctant to give in to his attempt to persuade you to say the single-payer system really is the solution, because it is what you do with the information, I think, that is most important. And the reason I think the managed-competition model probably has a greater chance for ferreting out fraud, is what you do with the information.

The requirement that insurance companies provide a single form and that there be a central collection of that information is not unique to a single-payer system, but who you give the information to, I think, is critical.

If you give it to Government, and Government is going to have to try to go ahead and continue to hire more cops to try to police the system, you will probably not be as successful as the people who are trying to figure out a way to get the maximum bang for the buck in a competitive model.

Have a yardstick, and I think that is what you are really saying, a common yardstick to measure activities in particular areas. First of all, the outliers jump out immediately. There are billing practices which come to the surface immediately. What do you do with that?

Obviously, you can channel it off into a legal area, if necessary, but, most importantly, isn't this evidence under, for example, a managed-competition model, to be provided to the consumers, not just the individuals, but also those various companies so that they can make an intelligent investment decision the next time? And fraud is not an intelligent investment.

The profit motive is probably the quickest way we are going to eradicate fraud. But the reason fraud exists is because you are unable to identify it, cleanly, first of all, and in a timeframe to do something about it, and almost always, the incentives are not great enough versus the cost of the fraud. And you made that point, I think, clearly to my friend from Washington. It has to be cost effective or people are not going to go out and try to get rid of it.

And to me, the most efficient method would be, first of all, a common yardstick to expose the outliers, and then a reason to go after them. One, it is costing me real money out of my pocket as an individual, not some government dedicated to doing good for its citizens sitting on top of a mass of information that moves like a bureaucracy moves, but that it is people who realize it is costing them money. They are not going to be able to get as much as they would otherwise if they allow fraud to continue.

So don't you think that the kind of insurance industry changes you are talking about don't require a leapfrog to a national Government-run single-payer system; that we can certainly implement the kind of suggestions you indicate, falling far short of that monolithic model?

Ms. SHIKLES. Yes, our recommendations have really no relationship to the kind of health care system that you might want to move to. There are changes that could be put in place with our current system and we envision them being implemented with the cooperation and support of all the different payers and providers doing some things that make sense, that try to get at that small group who are causing us problems, without being overregulatory or overbureaucratic about it.

Mr. THOMAS. Thank you.

Chairman STARK. Janet, I want to thank you very much for your testimony.

I would also like to say, for the members of the committee, that to perhaps shorten up this debate over a variety of competing medical or health reform plans, that we use as our model the

Fredonian system for the rest of this hearing, and that will be neutral as to all of our——

Mr. LEVIN. Mr. Chairman, I was not quite sure of your reference, but you make sense. Because I think there is a tendency, Mr. Chairman, for us to take every issue and to try to fit it into the overall system that we want adopted. And it seems to me that the cogent testimony here is we better get busy, and we have a major problem here, and it is going to have to be resolved whichever system is adopted.

Mr. THOMAS. As long, Mr. Chairman, as we remember the Fredonians have a long history of the private sector defining their economic activities and their beliefs in individual rights.

Mr. LEVIN. Mr. McDermott has a different reading of Fredonia.

Mr. MCDERMOTT. The Fredonians have allowed the costs to get to $850 billion, and now they say, well, we want to make some changes and we are going to now get costs under control. Seems a little late.

Chairman STARK. OK. We are going to continue with testimony from our witness.

We will now hear from Larry Morey, Deputy Inspector General for Investigations at the Department of Health and Human Services.

I think we have seen Larry here in the past accompanying his former boss. It is good to have you back with the committee. Your entire statement will be in the record, and we would ask you to summarize your testimony in any manner you are comfortable. Why don't you proceed.

STATEMENT OF LARRY MOREY, DEPUTY INSPECTOR GENERAL FOR INVESTIGATIONS, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, OFFICE OF THE INSPECTOR GENERAL

Mr. MOREY. Thank you, Mr. Chairman and members of the committee. I appreciate the opportunity of testifying on health care fraud this afternoon. I have submitted my written statement and would request that it be entered into the record.

Chairman STARK. Without objection.

Mr. MOREY. Identifying health care fraud is one of the top priorities at the Office of Inspector General of the Department of Health and Human Services. As the Deputy Inspector General for Investigations, it is my responsibility to not only identify health care fraud, but then to investigate it. We at the OIG appreciate this committee's efforts and their commitment to the fight against health care fraud and your support of the OIG in our fight against health care fraud.

I believe that we are still falling further and further behind in our battle against health care fraud. Over the past 10 years, our health care convictions have increased from 20 back in 1981 to 168 in 1992 for about an 800 percent increase. This is our twelfth consecutive year in a row that we have had an increase in health care convictions.

An even more dramatic increase I believe is occurring in the policing of those who would abuse our health care programs and our beneficiaries, but whose wrongdoing is falling short of that which

is necessary to obtain a criminal conviction. Last year, for example, we administratively sanctioned 1,700 health care providers out of our program. That is 44 times the number that were sanctioned in 1981.

I take a look at that tremendous increase in the need for those administrative sanctions, it implies to me that we are falling further and further behind in our health care battle.

The Omnibus Budget Reconciliation Act of 1981 authorized the inspector general to impose civil money penalties against those health care providers that would provide illegal claims for reimbursement from our programs. Specifically, that law authorized the OIG to impose sanctions of up to $2,000 for each false claim that was submitted and then to total the amount of fraudulent claims and levy twice that amount as an assessment.

I would like to report back that as of fiscal year 1992, we have recovered over $245 million through that process, and that equates to about 846 settlements. As you are aware, in December of 1992, we used that authority to impose the $100 million settlement with the National Health Laboratories in California, and of course, that was for the submission of false claims. That is the largest health care settlement that the Government has entered into to date, and again for point of reference, it just confirms to me that this battle on health care fraud is a continuing battle and far from over.

The OIG has been on the front line of this health care battle for the past 16 years. Congress has given us that responsibility, and I think we have been successful in our mission. I will state that I think that health care fraud changes daily, and we have been unable to keep up with it. For example, health care fraud has an ability to adapt to change, and every time we change our program, it changes along with us.

For example, we went to the outpatient hospital expenses with the hopes that it would reduce the inpatient hospital costs, and what we have found is that the fraud has followed the patient home. Now we are experiencing fraud in our home infusion programs. We are experiencing fraud in home therapy programs. So this is a great challenge for us, and as we look at that industry, we see that fraud is occurring in home infusion companies as they pay kickbacks for patient referrals, and we are noticing an excessive cost in the treatment that is received in our homes.

While the department outlays are increasing this year by $40 billion alone, again the OIG is finding that we are underfunded. I can only tell you what that does to my office. We have lost 70 employees, or 15 percent. I have lost 17 percent of my criminal investigators in the health care arena. Now this reduction has certainly hurt us at a time when health care fraud is increasing.

I would remind you that over the years the funding that Congress has given us has been a good investment. In 1992, we returned $61 through fines, savings, penalties and interest for every $1 that was invested in our operation. There is certainly much more that needs to be done, and with the continued support of Congress, we will be able to do more.

I have mentioned that we have problems with resources; we have money problems. We also have additional problems with not having enough law enforcement authorities to do our job. Too much of my

valuable time is wasted by not having those law enforcement authorities. We have had subjects flee our country, and they have fled our country with ill-gotten gains, because we didn't have the authority to prevent that. We have had valuable documents destroyed; we have had witnesses placed in danger; our special agents have been placed in danger, and if your committee could consider some of these problems that we have, I would appreciate it.

I am available to answer your questions.

Chairman STARK. Thank you very much.

[The prepared statement follows:]

STATEMENT BY

LARRY MOREY
DEPUTY INSPECTOR GENERAL FOR INVESTIGATIONS
OFFICE OF INSPECTOR GENERAL
DEPARTMENT OF HEALTH AND HUMAN SERVICES

FOR OVERSIGHT HEARINGS BEFORE THE

HOUSE COMMITTEE ON WAYS AND MEANS
SUBCOMMITTEE ON HEALTH

MARCH 8, 1993

Good morning Mr. Chairman and Members of the Subcommittee. I am Larry Morey, Deputy Inspector General of the Office of Inspector General (OIG). Thank you for the opportunity to testify on the subject of health care fraud in the Medicare program and what can be done to reduce it. We are pleased that the subcommittee is holding this hearing to discuss the important issue of health care fraud -- a problem that squanders our valuable resources and can adversely affect the health of our beneficiaries. At a time when health care reform is being debated, it is also appropriate that we address these issues to assure that our public health programs operate efficiently and effectively and that changes in our health care financing and delivery systems are made in a manner that minimizes the potential for fraud, waste, and abuse.

The rapid rise in expenditures and deficiencies in our health care delivery system has caused unprecedented attention and scrutiny in the health care area. This scrutiny has encompassed discussions regarding the magnitude and pervasiveness of fraud, waste, and abuse in our health care programs. As you know, the General Accounting Office (GAO) recently released a report entitled, *Health Insurance: Vulnerable Payers Lose Billions to Fraud and Abuse*. The report quotes experts in the health field who estimate the losses to fraud and abuse in health care is 10 percent, or approximately $80 billion in 1992. We will discuss our experience in investigating Medicare and Medicaid fraud later in our testimony.

In discussing monetary losses to health programs, a distinction must be made between fraud, abuse, and waste. It is impossible to distinguish sharply between these terms since frequently one problem involves all three. However, for purposes of rough definitions, we provide the following:

- **Fraud** is defined as the obtaining of something of value, through intentional misrepresentation or concealment of material facts.

- **Abuse** may be defined as any practice which is not consistent with the purpose of providing beneficiaries with medical services which are (1) medically necessary, (2) meet professionally recognized standards, and (3) fairly priced.

- **Waste** is the incurring of unnecessary costs as a result of deficient practices, systems, or controls.

Current Health Care Delivery

Currently, Americans are devoting more than 12 percent of our gross national product (GNP) to health care. Roughly three quarters of a trillion dollars were spent in this country on health care last year. This figure is expected to rise dramatically -- one projection indicates that health care expenditures could consume 31.5 percent of our GNP by the year 2020.

The Department of Health and Human Services (HHS) is the Federal Government's principal agency for promoting the health and welfare of Americans and providing essential human services to persons of every age group. The Department's two largest health programs are

the Medicare and Medicaid programs, which are administered by the Health Care Financing Administration (HCFA). Medicare provides health insurance coverage to approximately 36 million beneficiaries aged 65 and older and to certain disabled individuals. The Medicaid program provides grants to States for the medical care of more than 30 million low-income people. Expenditures for the Medicare program totalled $140 billion in FY 1992 and expenditures for Medicaid totalled $100 billion ($72 billion Federal share).

Fraud and Abuse Investigations

Created in 1976, the OIG is statutorily charged to protect the integrity of departmental programs, as well as promote their economy, efficiency and effectiveness. We meet our challenge through a comprehensive program of audits, inspections, program evaluations, and investigations. We are pleased with the accomplishments we have had in ensuring that beneficiaries receive quality care, that the integrity of the trust fund is maintained and that those individuals who defraud the Department's programs are held responsible for their actions.

Over the years, the OIG has proved that to be a sound investment. In FY 1992, the OIG generated savings, restitutions, penalties and interest of over $61 for each Federal dollar invested in its operation. In FY 1992, we imposed 1,739 administrative sanctions on individuals and entities who defrauded or abused the Medicare and Medicaid programs or their beneficiaries. That is more than 44 times the level we reported in 1981. Successful health care prosecutions in the criminal courts have also dramatically increased, from 20 in 1982 to 168 in FY 1992. In fact, FY 1992 marked our 12th consecutive increase in successful prosecutions.

The OIG has always been innovative and active in investigating health care fraud. With 16 years of successful investigations in Medicare fraud, we have the most experience of any Federal agency in investigating health care fraud. We continue to share our knowledge in this complex field of health care fraud and abuse by providing training to such agencies as the FBI, among others. The OIG and the State Medicaid fraud control units (MFCUs), have concurrent investigative authority in the Medicaid program and conduct joint investigations. The MFCUs, supported largely (75-90 percent) by Federal dollars, devote over 1,000 MFCU personnel to investigating Medicaid fraud. Currently, Federal outlays for operation of the MFCUs are in excess of $50 million. (By contrast, the OIG is funded for only 110 investigators to investigate both the Medicare and Medicaid programs, including the 11 States that do not have Medicaid fraud units. In summary, OIG has roughly 10 percent of the MFCU staff resources and slightly more than one-third the MFCU financial resources to cover its broader statutory mandate.)

We also work closely with HCFA and the Medicare contractors that process Medicare claims and perform payment safeguard functions. As a result of our recommendations over the last several years, HCFA initiated a broad effort to get the Medicare contractors to take a more active role in detecting, developing and referring potential fraud cases to the OIG. Among the changes that HCFA implemented was the creation of fraud units within most Medicare contractors. We believe that this will create a significant increase in quality case referrals to our office from the contractors. I also note that other law enforcement agencies continue to seek greater access to contractor data. Since, by statute, our agency is the only point of access for other law enforcement agencies, we believe we will be called on for assistance at a much greater rate than ever before.

Until recently, private health insurance programs had no significant investigative response to fraud. To address this issue, in 1985 we helped launch and were one of the founding members of the National Health Care Anti-Fraud Association (NHCAA). It is a consortium of our office, the Department of Justice (DOJ), FBI, MFCUs, private health insurers, and others who coordinate and share information and techniques for dealing with health care fraud. Our office has been on the board of directors since its inception. In addition to working on joint projects with this group, we help train the members in better detection techniques and alert them to new types of health fraud.

Prior to the inception of the NHCAA, private carriers did not have a means to share information in order to enhance the identification, prevention, detection, and prosecution of health care fraud. NHCAA was established on the premise that the diverse interests of health insurance reimbursement organizations, Blue Cross and Blue Shield organizations, private corporations and Federal and State agencies and law enforcement operations could be channeled toward a common goal. The association currently consists of several hundred representatives from these types of organizations. NHCAA promotes information sharing among members (with appropriate legal safeguards), engages in public education on health care fraud issues, trains members and non-members through national and regional conferences, seminars, and workshops, and serves in an advisory capacity to industry, regulatory, and legislative bodies.

As an example of the complicated nature of health care fraud investigations, I would like to describe the activities of the Southern Ohio Health Care Task Force (SOHCTF). One of its primary objectives is to focus on fraud cases which are difficult to detect. The investigations involve the coordination of both the criminal and civil divisions of the United States Attorneys's Office. The task force began in October 1991 and is comprised of members of the United States Attorneys's Office for the Southern District of Ohio and special agents from the OIG, FBI, and the Postal Inspectors Office. Other agencies, such as the Railroad Retirement Board and CHAMPUS may also become involved on a case by case basis. The task force seeks to ensure that not only will all criminal prosecutions proceed quickly, but also that the appropriate civil remedies are instituted and that complete restitution is made to ensure the public that funds, such as the Medicare trust fund, are restored for future generations. We try to prove the civil case, while simultaneously attacking the criminal aspect. The benefit of working a parallel investigation, in which civil and criminal case are being investigated concurrently, is that many of the assets illegally obtained by the provider can be confiscated and/or frozen, preventing the provider from disposing of the them prior to criminal prosecution. At any given time, the SOHCTF has approximately 30 cases under at some stage of investigation. To date, 12 cases have been successfully prosecuted by the SOHCTF.

Medicare and Medicaid Fraud and Abuse Vulnerabilities

Fraud is invisible until detected. Because of that fact, it is extremely difficult to estimate the total monetary loss as a result of fraud in the health care industry. While we cannot assign a dollar figure to the monetary loss to the Medicare and Medicaid programs as a result of fraud, we can tell you that we have noticed a dramatic increase in our investigative workload. This is caused, in part, by the ever expanding size of these programs. The increase in administrative and prosecutable authorities that the Congress has enacted is also a contributing factor. Finally, there may also be an increase in fraud in absolute terms.

In the 1970s, we found that we were dealing with individual provider fraud which involved relatively uncomplicated schemes, such as filing a false claim and resulted in a few thousand dollars of damage to the Medicare program. Today, however, instead of schemes which involve only one person or entity, it is now common to see cases involving groups of people who are intent on defrauding the Government. These schemes are perpetrated in a far more complex environment and often involve the use of sophisticated computer techniques and complicated business arrangements. These crimes frequently result in tens of millions of dollars in losses to Medicare and Medicaid, as well as other public and private health insurance programs.

Because of the limited time we have today, we have selected a few examples of fraudulent and abusive practices that will give you a broad overview of our office's investigations.

Billing For Services Not Rendered -- The majority of our workload continues to involve billings for services not rendered. These cases are more readily accepted for prosecution by the United States Attorney and are responsible for the bulk of the convictions obtained in the health care field.

Inaccurate Claims -- The Medicare program loses money when providers submit inaccurate claims that do not reflect the services actually performed or the supplies actually delivered. Gaming can take the form of unbundling and upcoding. Unbundling occurs when providers inflate charges far above the appropriate level by billing for the subcomponent parts of an item or service rather than the complete item or service. Upcoding is the practice of billing for a more intensive service than the one actually delivered.

Kickbacks -- Physician ownership of and compensation from entities to which they make referrals is a practice that has increased considerably in the last 10 years. The medical profession relies heavily upon referrals because of the myriad specialties and technology associated with health care. If referrals of Medicare or Medicaid patients are made in exchange for anything of value, however, both the giver and receiver may violate the Federal anti-kickback statute. Since 1987, we have received more than 1,569 allegations of violations of the anti-kickback statute, and have opened over 1,012 cases. Over 635 convictions, settlements, and exclusions have been obtained as a result of our investigations, as well as almost $18.2 million in monetary recoveries. Research continues to determine the extent to which increased costs are a problem for other items and services that these joint ventures furnish.

Home Health Agency Fraud -- Home health agencies (HHA) provide care in the patient's home, with limited supervision by the attending physician. There are several categories of fraud which we have seen in HHA operations: cost report fraud; excessive services or services not rendered; use of unlicensed or untrained staff; falsified plans of care and forged physician's signatures; kickbacks; and intermediary hopping. Since 1986, we have concluded 24 successful criminal prosecutions of HHAs and their employees. Since 1991, we have excluded 15 HHAs, owners or employees from participating in Medicare.

Psychiatric Clinics -- Fraud involving psychiatric clinics can take many forms. In a scheme we have seen recently, hospitals pay physicians up to $2,000 for the referral of patients to the facility. The amount of money is dependent on the number of patients referred to the hospital by the doctors. The payments to the doctors by the hospital are included as part of the costs incurred by the hospital on the cost reports that are submitted to Medicare. The payments received by the doctors are ostensibly for the writing of patient care manuals that will be utilized by the hospital in its care of the patients, but these manuals are never written. Services for both inpatients and outpatients are not rendered by the hospitals. In some instances, when the Medicare benefits run out for a particular diagnosis, the patient is re-diagnosed to ensure Medicare or Medicaid coverage.

Durable Medical Equipment (DME) -- For many years, we have issued reports documenting fraudulent, abusive and wasteful practices in the DME area. Seat lift mechanisms, transcutaneous electrical nerve stimulators, oxygen equipment, home dialysis systems and similar equipment are reimbursed by Medicare and Medicaid only if prescribed by physicians as medically necessary. Unscrupulous suppliers throughout the country circumvent this requirement through aggressive sales practices, tricking physicians into signing authorizations and even forging their signature. Some suppliers simply bill for items never delivered; others bill carriers in States which pay high Medicare reimbursement, regardless of where the sale took place. In the last 3 years alone, over 80 convictions have been obtained in this area. We are pleased that the Department is currently undertaking reforms which will change point-of-sale rules and how provider numbers are issued.

Laboratory Fraud -- We have encountered a number of schemes in the laboratory industry: (1) billing for services never rendered, (2) unauthorized or excessive tests, and (3) disguising billing procedures in which the carrier is actually billed twice. In the last 5 years, almost 50 convictions and civil actions have been obtained as a result of our laboratory investigations.

Hospital Credit Balances -- The OIG has documented that the Medicare program loses millions of dollars because Medicare credit balances are not returned to the Government (about $266 million when we conducted our report). Credit balances occur because (1) Medicare is billed twice, (2) services are reimbursed by another insurer as well as Medicare and (3) services are billed but never rendered. While credit balances are an overpayment

and monies should be recouped by the Government, in some instances we believe that fraud has been perpetrated. We are currently investigating certain facilities to determine whether criminal prosecution is warranted.

Patient and Program Protection Sanctions -- The Medicare and Medicaid Patient and Program Protection Act (Public Law 100-93) provides a wide range of authorities to exclude individuals and entities from the Medicare, Medicaid, Maternal and Child Health, and Block Grants to States for Social Services programs. Exclusions can now be imposed for conviction of fraud against a private health insurer, obstruction of an investigation, and controlled substance abuse, as well as for revocation or surrender of a health care license. Exclusion is mandatory for those convicted of program-related crimes or patient abuse. During FY 1992, the OIG imposed 1,739 sanctions.

Civil Monetary Penalties for False Claims -- Under the civil monetary penalty (CMP) authorities enacted by the Congress, OIG may impose penalties and assessments against health care providers who submit false claims to the Medicare and State health care programs. The CMP law, therefore, allows recoupment of some of the monies lost through illegitimate claims, but it also protects health care providers by affording them due process rights similar to those available in the administrative sanction process. Many providers, however, elect to settle their cases prior to litigation. During FY 1992, the OIG recouped more than $28 million through 136 CMP settlements and hearing decisions.

As I have previously stated, there are no clear lines of distinction among the many types of fraud we investigate. As an example of a cross-cutting case involving laboratory fraud, kickbacks, and upcoding, I want to describe our recent $111.5 million investigation of National Health Laboratories, Inc. (NHL). The NHL is a major blood testing laboratory headquartered in California which pled guilty to submitting false claims to the Government and agreed to pay $100 million in a global civil settlement for defrauding Medicare by manipulating doctors into ordering medically unnecessary tests. The settlement is the largest ever reached between the Government and a health care provider in a health care fraud case. The NHL also will pay a criminal fine of $1 million and reimburse State Medicaid agencies $10 million for their losses attributable to criminal conduct. The president and chief executive officer of NHL also pled guilty and will forfeit $500,000. The agreement settles claims that NHL added high density lipoprotein cholesterol tests and iron storage tests to the series of blood tests doctors order most. This series of tests is most used because it is highly informative and relatively low-cost. By 1989, NHL was performing about 7 million of these tests a year. The two extra tests, however, were not really part of the series run, and were billed separately to Medicare regardless of whether the doctors had ordered them. The OIG agents conducted interviews and investigations throughout the country and determined the magnitude of the fraud during the course of the 3 year investigation. Through NHL's scheme, the company knowingly submitted a large number of false claims for payment from 1987 to the present.

Reforms Needed

As this Subcommittee is well aware, the OIG is also statutorily charged with promoting the economy and efficiency of the programs operated in HHS. For many years, we have been concerned about the efficiency of the Medicare and Medicaid programs in particular, as the costs have continued to escalate at the expense of the solvency of the trust funds.

As a result of these concerns, we have devoted a significant part of our office's resources toward analyzing the effectiveness of these programs and in identifying areas that have excessive waste. We are pleased that in the past the Congress and the Administration have enacted many of our recommendations which have improved the efficiency and effectiveness of our programs and have improved the solvency of the trust funds. As policy makers consider ways to reform the health care system, lessons drawn from the Medicare program and its vulnerability to fraud, waste, and abuse can be instructive. We believe that there are four overall categories of deficiencies in these programs which require further legislative or administrative modification: (1) some payments are excessive, (2) unnecessary and

inappropriate care is rendered to beneficiaries, (3) financial conflicts of interest exist, and (4) Medicare systems are vulnerable to manipulation. Many of these areas merit further attention and corrective action. A listing of our significant unimplemented monetary recommendations can be found in our *Cost-Savers Handbook*, referred to as the *Red Book*. A listing of our significant unimplemented nonmonetary findings can be found in our *Program and Management Improvement Recommendations* referred to as the *Orange Book*. The following represents some of our unimplemented recommendations which we believe could lead to greater program efficiency.

- **PPS Capital Payments.** In an April 1992 OIG report entitled *Analysis of Capital Costs* (A-09-91-00070), we recommended that HCFA propose legislation to continue mandated reductions in capital payments beyond FY 1995. This recommendation was made after the OIG determined that historical costs used in setting PPS rates were inflated because of excess hospital capacity and the inclusion of inappropriate elements.

- **Indirect Medical Education.** In a report entitled *Hospital Profitability in the Fourth Year of the Medicare Prospective Payment System*, (A-07-88-00111, September 1989), the OIG documented that teaching hospitals were more profitable than nonteaching hospitals and recommended that HCFA proposed legislation to further reduce the IME factor.

- **Laboratory Payments.** In a report entitled *Changes are Needed in the Way Medicare Pays for Clinical Laboratory Tests* (CIN: A-09-89-00031, January 1990), the OIG determined that Medicare was paying nearly twice as much as physicians for the same tests. We recommended that HCFA bring the Medicare fee schedules allowances in line with the prices physicians are paying for tests purchased from independent laboratories. Also, In a report entitled *Medicare Reimbursement for Outpatient Laboratory Services*, (OAI-02-89-01910, May 1989), the OIG recommended that HCFA continue to take advantage of the economies of scale present in the laboratory industry by considering competitive bidding or making reductions in the fee schedule amounts.

- **Medicare Secondary Payer (MSP).** Medicare is the secondary payer to certain employer health plans for beneficiaries age 65 and older, disabled beneficiaries, and during the first 18 months of a beneficiary's entitlement to Medicare on the basis of end stage renal disease (ESRD). Noncompliance with the MSP statute has been documented for years and our office has issued numerous reports on this subject. Both administrative and legislative action has been taken to correct the problem. However, loses continue and as of September 1992, HCFA reported about $961.6 million in past MSP payments that had not been collected. An OIG report entitled *Extent of Unrecovered Medicare Secondary Payer Funds* (OEI-07-90-00760, August 1991) recommended that HCFA should recommend to Congress that section 6202 of Public Law 101-239 (as amended by Public Law 101-508) be extended beyond the statute's termination date of September 30, 1995 until legislation is enacted requiring direct employer reporting. We have also recommended that the W-2 form be modified to collect private health insurance information.

  In a report entitled *Amending the Medicare Secondary Payer Provision for ESRD Beneficiaries Could Save the Medicare Program $3 Billion Over the Next 5 Years* (A-10-86-62016, December 1987), the OIG recommended that the MSP provision for ESRD beneficiaries be extended to the time that the beneficiary is covered by an employer group health plan (EGHP). This change would make the MSP provision consistent with legislation passed by the Congress for aged and disabled beneficiaries, which does not restrict the period of time that Medicare would be secondary payer.

- **Hospital Outpatient Departments.** An OIG report entitled *Medicare Reimbursement for Hospital Outpatient Department Services* (A-14-89-00221, March 1991) found that a reduction of 12.5 percent in Medicare's payments for OPD services would bring

OPD payments in line with payments to ASCs for similar services. Also, a June 1991 report entitled *Reimbursement for Outpatient Facilities Services* (OEI-09-88-01003) recommended that HCFA seek legislation to achieve parity in ASC and OPD payments.

- **Payments for Epogen.** EPO is the drug used by patients suffering from kidney failure, to counter anemia by increasing the body's production of red blood cells. In a February 1993 report entitled *Review of Epogen Reimbursement* (A-01-92-00506), we determined that the cost of EPO was between $10 and $10.10 per 1000 units administered and we recommended that the payment rate for EPO be reduced to this level.

- **Medicaid estate recovery/transfer of assets rules.** In an August 1988 report, *Medicaid Estate Recoveries* (OAI-09-86-00078), the OIG proposed several changes in Medicaid's rules regarding estate recoveries and processes. These changes would reduce Medicaid's ultimate liability for the costs of nursing home care while, in certain circumstances, enabling close relatives of someone admitted to Medicaid-financed nursing home care to continue using assets, such as a house, that they had shared with the admitted person. The recommendations would strengthen transfer-of-asset rules to further restrict the giving away of property and would encourage State Medicaid programs to protect dependent or incompetent recipients from financial exploitation by relatives. In June 1989, the OIG issued a report, *Transfer of Assets in the Medicaid Program: A Case Study in Washington State* (OAI-09-88-01340) and recently began a follow-up study, *Sheltering of Assets to Qualify for Medicaid* (OEI-07-92-00880). The first phase of this new study will be to produce a summary of current literature on Medicaid estate transfers and asset recovery programs. In the second phase, we will conduct a survey of States to determine whether States have programs to prevent illegal transfer of assets and to recover assets.

- **Medicaid Prescription Drugs.** A March 1991 OIG study, *Strategies to Reduce Medicaid Drug Expenditures* (OEI-12-90-00800) evaluated strategies used by State Medicaid Agencies and Canadian provinces in reducing their drug costs and proposes a series of actions to prevent unnecessary payments for prescription drugs. We found that implementing restricted drug lists in 29 non-restricted States would result in Federal and State savings of $226 million per year.

In addition to reports issued by our office, an Interagency Task Force on Health Care Anti-Fraud, Abuse and Waste has recently issued a variety of proposals designed to reduce the level of fraud, waste, and abuse in Medicare and other health insurance programs. These proposals include the following:

- The current Medicare-Medicaid prohibition on kickbacks should be extended to all public and private payers.

- The current Medicare ban on payments for self-referrals should be expanded to additional services where the physician does not directly render the service and where abuses have been identified.

- The Medicare-Medicaid civil monetary penalty statutes and the Quality of Care sanctions should be strengthened to deter abuses.

- The routine waiver of Medicare Part B coinsurance except for low-income beneficiaries should be explicitly prohibited.

- Databases of all final adverse actions and certain active fraud investigations against health care practitioners should be established with appropriate safeguards for privacy and access.

- Standards to ensure accountability in the electronic media claims process should be

developed. This should include provisions to ensure that (1) providers are held accountable for the accuracy, completeness, and truthfulness of claims submitted on their behalf, (2) the identity of the individual that caused the transmission of the claim is known, and (3) the patient is provided with information regarding the type of services for which reimbursement is claimed in order to be able to verify them.

Conclusion

The types of fraud that I have discussed in my testimony today could be avoided or lessened by closing loopholes that exist in the law or in Medicare rules and regulations. Hearings such as this help draw attention to these important problems that confront and weaken our health care delivery system. This concludes my prepared testimony. I shall be happy to answer any questions you may have.

Chairman STARK. What is that? You mentioned earlier administrative sanctions. Let's suppose that I have been caught running a laboratory and I am performing tests and I really don't. How do you sanction me? Do you just warn me to cut it out or do you fine me? What is an administrative sanction?

Mr. MOREY. Well, generally the administrative sanction occurs as a result of a criminal conviction, so that would have probably been a criminal case to begin with, and after we have adjudicated that through the criminal process, then we would impose upon you an administrative sanction.

That is a mandatory sanction and you would be out of our program for 5 years.

Chairman STARK. There is nothing in between, I mean like a warning?

Mr. MOREY. We have some permissive sanctions, that it is up to us to decide whether or not it has been so egregious that we want to take you out of our program. We have about 60 permissive sanctions and we have about 20 mandatory exclusions. So yes, there are items in between, and we do test your willingness and ableness to correct your deficiencies, but if after we have sent you a letter, if you are not inclined to go along with us, then we will impose the permissive sanction.

Chairman STARK. What are your three largest areas, or two largest areas of fraudulent activity?

Mr. MOREY. Well, I certainly think the number one is billing for services not rendered. We are continually amazed at the claims that we get where the services were never rendered, and it is just false on its statement.

The next area that seems to inflict the most pain on us is patient referrals. We are in a society where the competition is such that there is a degree of activity out there to solicit patients, so we are experiencing a lot of problems with patient referrals.

Chairman STARK. What would be third?

Mr. MOREY. Well, we certainly have a lot of hospital and clinical tests that are run that just probably were not necessary to begin with.

Chairman STARK. So on the one hand, it is just absolute stealing, fraudulent billing, might as well be akin to counterfeiting or issuing phony stock certificates. I mean sending you a bill for something that never happened.

Mr. MOREY. That is true.

Chairman STARK. What percentage would you guess, Larry?

Mr. MOREY. Oh, I would say it is high. In our fraud area I would say that that is at least 50 percent of it.

Chairman STARK. And then referrals are just necessarily raising the price of something by giving a commission or a kickback or sharing the fees?

Mr. MOREY. Yes. What it generally does is it leads to overutilization.

Chairman STARK. Now, those two, the referrals and the phony billing are pretty straight investigative. You don't have to be a physician to know the service was never provided, you just have to be a good investigator.

What I am getting at is you don't have to have MDs out checking that sort of thing, or even for the referrals. That is pretty straight kind of white collar crime, is it not?

The third area is the unnecessary or overutilization, and there, don't you run into the question of needing special opinions, whether it is the view of a peer review by doctors? Are you capable, or are there people on your staff capable of determining what is improper or over or unnecessary utilization? How do you define that?

Mr. MOREY. Well, Mr. Chairman, I think we take a look at the percentage that the person is billing in that area as compared to the physicians or rest of the hospitals in the area, and when we notice somebody is really far off the map, then, yes, we know we have a problem, but we do seek other counsel.

Chairman STARK. OK. Of course you only investigate Medicare and Medicaid crimes, but can you give the committee any hint as to how beneficial you think it would be to extend these laws and tighten them to all payers, so that everybody had to operate under the same set of rules? What advantages would there be to the public from that?

Mr. MOREY. For the past 10 years I have worked extensively with private industries, and I certainly would support any effort that we can give them to eliminate some of the problems that they are having, and they are having the same problems we have.

Chairman STARK. OK. Thank you.

Mr. Thomas.

Mr. THOMAS. Thank you, Mr. Chairman. I think that is important. It isn't that it is the Government out there against everybody else; it is the honest people against the crooks, and that is an age-old battle. I am amazed that 50 percent of the fraud is that they bill for a service which was never rendered in the first place, just flat-out lying, cheating, and don't you usually find that people's willingness to engage in this kind of a behavior is inverse to their belief that they are going to get caught?

Mr. MOREY. Yes, and I don't believe these people think they are going to get caught.

Mr. THOMAS. Now, somebody does it and gets away with it. You indicated that there is a growing sophistication to some of the fraud. They obviously communicate it to others. I don't think it is a genetic defect we are dealing with here. They have to communicate it in some way.

Do we not have adequate laws, or do you find that you can't use the laws we have in terms of mail fraud, the classic example, or phones? What about computers? Do we have adequate laws in place against the transmitting of this kind of information over computer lines, mail, phones, other sources of communication?

Mr. MOREY. I think basically we have—the vast majority of the laws already on the books that will get us through most of our investigations. There are a couple of areas that we could adjust to improve the investigator's life.

Mr. THOMAS. So from a detection technology point of view, you think we are adequate?

Mr. MOREY. Yes, I think the statute will allow us to get into court all the cases that we want to. There are a couple of areas that we could improve upon and it would make it easier for us.

Mr. THOMAS. Do the providers, either insurance or medical, appear to be cooperative? Is there a structure in which you are able to cooperate, or do you find that currently laws either do not allow you to transfer information, or you just don't have the right tools for law abiding folks in the same areas to communicate and cooperate?

Mr. MOREY. I think between law enforcement officers, there is a lot of cooperation. Certainly with my organization and the FBI, we don't have any problems with the postal service. But as you get into the private area, you would certainly have a lot of problems. For example, I can't investigate outside of Medicaid or Medicare, so I am really not much use to the private sector in that respect.

When the private sector uncovers a fraud, it is generally in the private sector and we both know that it is probably being perpetrated on the Medicaid/Medicare side, but they don't have access to that, so if they were to tell me about the fraud, it is: I don't know if it is occurring or not, Larry, you can check it out.

Mr. THOMAS. Big bucks, relatively slight possibility of getting caught, white collar crime, those all kind of profile organized crime. Have you found to any extent organized crime moving into this area because of the amount of money involved, or are we still dealing with individual entrepreneurial crooks?

Mr. MOREY. Well, I think it is individual, but the word "organized" in the traditional sense, no, I don't think there is organized crime in it. But the crime that we are seeing is certainly organized on a small basis. Like, for example, a clinic that was perpetrating a fraud is certainly organized in the fact that the way they perpetrate the fraud is not haphazard.

Mr. THOMAS. So more and more, part of the sophistication is that they are going into activities with the clear intent to defraud, rather than in their ongoing business they have found ways in which to change so that they can practice fraud; is that what you are saying?

Mr. MOREY. I think that is basically correct, yes. People are looking for the way to make this possible, and with the volume of paperwork that we have and the great paper system and all these claims that need review, et cetera. It encourages maybe the submission of a claim that is fraudulent.

Mr. THOMAS. As the IG you have looked at it from the back side, not the front side, the back side of the problem. What probably is the single most important thing we could do, one, to make your job easier, which means make it more difficult to commit fraud?

Mr. MOREY. Well, if there was a Christmas tree here, I would do a lot of picking, but if you hit me with just the one——

Mr. THOMAS. Well, I will let you have more than one.

Mr. MOREY. It is certainly resources. We certainly don't have enough resources to do the job that you would like us to do.

Mr. THOMAS. We would prefer to prevent it rather than detect it, and I understand the time you would take in arguing for the budget for the IG, and I agree with you. But I am looking at it from another direction right now.

How can we help you go out of business is what I am saying? What could we do—for example, the single form insurance, obviously, would help. A central information site would help, but we

know about those. What do you have that you can contribute that might be something we wouldn't be aware of from the way in which you look at the problem versus the way others do?

Mr. MOREY. Well, I would only think that if people were more honest, we would probably be out of business. And if there was a good pill that we could all take, it would probably do away with the problem. But the system itself is perpetrated with so many holes that we would have to plug up all those holes to put me out of business.

Mr. THOMAS. A long time ago someone wiser than both of us said if all men were angels, we wouldn't need Governments either, but they are not, and we will try to make sure you get the adequate resources to do the job.

Thank you.

Chairman STARK. Mr. Levin.

Mr. LEVIN. Thank you. Welcome. If you would, based on all of your experiences, just respond to this. Do you think if we really get more serious about this problem and allocate the resources, change the laws that have to be altered, and make these other steps, can we really make a dent in this problem?

Mr. MOREY. Yes, I truly believe we can.

Mr. LEVIN. In your statement, you list some of the proposals that have been issued recently by the interagency task force. I take it you think these proposals could help the provisions on kickbacks extending them to all payers, expanding the present Medicare ban on self referrals to additional services.

We have tried to incorporate virtually all of these in the comprehensive bill or in companion legislation. I think they are examples of what we can do if we get really serious about this, and we really must. You think that feeling now pervades health care, the providers? Do you think there is now a sufficient level of concern that we can really, with some leadership, attack this problem much more successfully? Do you sense that the time is overdue and surely is ripe for movement?

Mr. MOREY. Well, I certainly do, Mr. Levin. I remember 10 years ago when we would read about health care fraud, maybe a health care provider or someone would say well, that is the only one, and today we know that there is a big problem out there. We know that our country is in a crisis situation with the expenditures in health care.

So I think from the medical community to law enforcement and to the American public, we are interested in resolving this problem.

Mr. LEVIN. Well, I hope so. You know, you somewhat perhaps surprised people listening when you said half of the problem is from claims on services never provided. I think all of us have been to town meetings where someone will get up and read from a bill, and some of the services the person says were never provided him or her.

And we have to establish a system in this country, both for the public and private sectors, where that problem is eliminated, and if it can't be done overnight, dramatically, dramatically reduced.

Thank you for your testimony.

Chairman STARK. Mrs. Johnson.

Mrs. JOHNSON. Thank you, Mr. Morey, for your testimony. On the Federal side, we and HHS, IGs, the FBI and the Medicaid fraud unit are investigating fraud, abuse and waste.

On the private side, how do private payers organize their fight against these problems? Is there any interconnection is what I am really asking, and how serious an impediment are antitrust laws and other laws that affect the ability of businesses to work together?

Mr. MOREY. Well, I think there are a few States that have been very helpful. There are a few insurance companies that have really taken fraud seriously. There is lots of fraud units in insurance companies beginning to appear where in the past there was not a fraud detection unit.

So I sense from the State level and from the insurance companies themselves, people that are providing health care, see we do have a problem here, and I get a sense that things are beginning to develop for all of us.

Mrs. JOHNSON. My understanding is that you are a founding member of the National Health Care Fraud Association. How has that association, the existence of that association fostered antifraud activities and how critical is that public/private communication to an effective solution?

Mr. MOREY. Well, I think it is very critical. We founded that association in 1985, at that time there were seven insurance companies that got together with HHS. It was the only association at that time, and I think it is still the only association that I am familiar with where you have the public and the private sector working together to resolve a fraudulent problem.

The insurance companies have rallied behind that association. I think the membership now is up to about 45 insurance companies. They are attempting to develop a data base where they could share information among themselves. It is certainly an attempt in the right direction to find out who is perpetrating the fraud so that we can do a better claim check of that individual or that corporation as we would process their billings.

So I think it has been very critical. The cooperation in that association has been a stimulus to my department, and we certainly support it.

Mrs. JOHNSON. It appears to me, because many of the insurers in my State have been very active, as you say, in the private effort, and in Connecticut's EDI project. From their work, coupled with your work, I would suspect that you need to have a lot of say in the development of the national data systems that we are inevitably going to be developing in support of health care reform.

Did you have any voice in the standardized billing proposals that the commission under the last administration developed, or any input into their commission's recommendations?

Mr. MOREY. I certainly had some input into the OMB study on what type of suggestions we might have to correct some of the health care problems, yes. As we are talking specifically about a standardized claim form, I am not very knowledgeable on what type of claim form has been generated.

Mrs. JOHNSON. And the data issue in the larger sense so that it can be developed in a way that will track patterns of practice, have you been involved in that at all?

Mr. MOREY. Only from the fact that we certainly do need some sort of a data base that would be effective for everyone.

Mrs. JOHNSON. What I have in the back of my mind, and I didn't make myself very clear, Mr. Morey, because it has been some time since I really have brought this information to bear. But there is a proposal for developing a kind of uniform clinical data set that will help us in reviewing hospital billing and in developing a greater insight into patterns of practice, and a lot of other things.

Now, how we do that is a big issue. But certainly, your advice ought to be heard in that dialog, because we need to do it in such a way that it makes fraud even more easily detectable and oversight, more effective. So I will see if I can get some of the information that I was working with about a year or so ago and send it to you and see that there is some way in which we should be working on that aspect of the problem.

Thank you.

Mr. LEVIN [presiding]. Mr. McDermott.

Mr. MCDERMOTT. In reading over your testimony, it appears that you assume that there would be no national health care reform. In other words, the recommendations you made assume a continuation of the present system?

Mr. MOREY. If it is crafted in that direction, I didn't intend it to be. If there is national health care reform, that would be all right.

Mr. MCDERMOTT. Well, let me tell you what I am driving at. In your testimony, you talk about some unimplemented recommendations we believe would lead to greater efficiency. You recommend the reduction of PPS capital payments. You recommend a reduction in indirect medical education funding. You recommend a reduction in laboratory payments, in hospital outpatient departments, and for the payments of Epogen.

All of these are specific things that apparently you have researched. It seems to me that this is simply the Federal Government saving money and shifting the cost on to the private sector. And I wonder if you see that as the effect of these kinds of recommendations. That is why I asked if you were looking at an overall system, or are you just looking at Federal Government costs and savings, regardless of private sector impact?

Mr. MOREY. I am sure on some of the studies that are referred to in that testimony, they certainly were just on the Federal sector. However, let me assure you that I personally think that the private sector has been out on a limb by itself for a long time. A lot of the authorities that Congress has given me to exercise, which would be very helpful in the private sector, so I am certainly concerned that if we correct anything in health care, that it is just not for Medicaid/Medicare, that it is extended to the private sector.

Mr. MCDERMOTT. Also, I have never heard teaching hospitals being referred to as more profitable than nonteaching hospitals. In what sense do you see a teaching hospital as being profitable? I think of that in the standard free enterprise system of profit and loss.

Is that what you are talking about here, that teaching hospitals are profitable?

Mr. MOREY. I think, as that report would indicate or illustrate, is that during a comparison our auditors determined that the teaching hospital had made probably an excess in funds versus a nonteaching hospital, and that they would probably not have to be reimbursed at the level that the Federal Government was reimbursing them.

Mr. MCDERMOTT. Knowing the financial difficulty teaching hospitals in big cities all over the country are in, it is hard for me to believe that the indirect medical education payment was leading to high teaching hospital profits. The problems of inner-city hospitals, it would seem to me, would not be solved by reducing that supplement that they have been getting over the last probably 8 or 9 years.

Mr. MOREY. I will be glad to furnish a copy of that report to you.

Mr. MCDERMOTT. I would like to see it.

Mr. MCDERMOTT. The other thing, I wonder about your laboratory payments. It says,

> We recommend that HCFA continue to take advantage of economies of scale present in the laboratory industry by considering competitive bidding or making reductions in the fee schedule amounts.

Does this report outline what kind of reductions and fee schedules they would make, arbitrary or on some basis?

Mr. MOREY. You know, I am not really familiar with that report enough to comment, but that is another one that I would be glad to furnish for the record.

Mr. MCDERMOTT. I would like to have a copy of that.

Thank you, Mr. Chairman.

[Mr. McDermott received the studies and a copy is also being retained in the committee files.]

Mr. LEVIN. Thank you. Anybody else have additional questions?

If not, thank you very, very much for your salient testimony.

Next we have an important panel: Mr. Mahon, Mr. Anderson, and Dr. Schenken. I think Mr. Anderson is accompanied by Charlotte Bartzack. Welcome. Perhaps if it is agreeable to you we will hear your testimony in the order that it was listed in our notice.

So Mr. Mahon, take over.

STATEMENT OF WILLIAM J. MAHON, EXECUTIVE DIRECTOR, NATIONAL HEALTH CARE ANTI-FRAUD ASSOCIATION

Mr. MAHON. Thank you, Mr. Levin. There are so many points that all of you on the subcommittee have raised so accurately so far, that we would like to spend a lot of time addressing each of them. I will summarize the prepared statement that I believe has been entered into the record, and I will also try to touch on some of the points that have been raised by the previous discussions.

Health care fraud is acknowledged increasingly to be a crime problem—and I emphasize that—of rather alarming national proportions. By the most conservative estimates among our members, who comprise the private sector health insurers and the public sector law enforcement organizations with jurisdiction over health care, we are losing between a minimum of 3 percent to perhaps as

much as 10 percent of our national health care expenditure every year.

This year the Commerce Department tells us we will spend just under $940 billion on health care. So by our math, we are looking at a minimum loss to fraud of $28 billion to perhaps as much as $94 or $95 billion. And again, that is to outright fraud.

I mention that it is a crime problem, because there has been discussion about the health care arena in which this activity takes place. In our feeling, we are looking at what is essentially a crime problem that takes place in the health care system.

We believe it is a very small proportion of the providers engaged in health care who engage in this sort of systematic, conscious, criminal attempt to defraud. The problem arises when you have so many hundreds of billions of dollars at play in the system that even a small number do rather massive financial damage, and in the process, in some cases, can put the health of individuals at risk, depending on the nature of the fraud scheme.

Mrs. Johnson asked Mr. Morey about the makeup of our organization. We are unique in combining the private sector health insurance antifraud professionals and the public sector law enforcement organizations who pursue health care fraud. That makeup is a direct reflection of the nature of the problem.

The fact is that the private sector and public sectors are victimized equally by the same defrauders, and as a result, you need a concerted effort by the public and private sectors, as well as a sharing of information among private sector insurers, in order to be effective against the problem.

To give you one anecdotal example from very recent days, 5 days ago in Los Angeles a couple was arrested and charged with a health care fraud scheme totaling $1.4 million and involving fictitious claims submitted against dozens of insurance companies.

One of our members in California, the Blue Cross Plan, was the initial reporting point for that scheme. They found an exposure on their part of $10,000 and reported it to the authorities. It is a perfect example to illustrate the nature of the problem, because in this case, one company's $10,000 exposure was the tip of what is now charged to be a $1.4 billion fraud involving quite a few entities. That is the fundamental nature of the problem that spells the difficulties that arise in going after it.

As you have noted, it is anything but a victimless crime. When we look at the kind of financial loss we are sustaining, the insurers and the Government may be the immediate victims of the loss, but there is no mistake that in the end it is all of us around the table here and in this room, and our families and associates, and employers who pay the cost of health care fraud, one way or the other.

As I mentioned, in some cases people's health is put at risk. That is something that can't be overlooked in the process; nor can the interest of employers who pay the cost of health care for their employees be overlooked. They represent a critical constituency in any effort to make us all better consumers of health care services and better watchdogs against health care fraud. Those businesses are sustaining enormous annual increases in the cost of providing health care insurance to their employees, and they need to be alert, as we all do.

I would respond to Mr. Thomas's observations about consumerism by simply saying we all need to pay as close attention to the insurer's statements of what is paid on our behalf as we would to a monthly credit card bill or a Sears bill to make sure that what was paid for was, in fact, what was provided. No question, we need to be better consumers.

I don't want to run long, so I will just note, too, that one of the other areas mentioned, electronic data interchange, presents a variety of potentially new challenges in going after fraud. On the one hand, we are dealing with a system that is geared to paying claims more and more rapidly and efficiently.

That system rests on an assumption of honesty on the part of all concerned. So, on the one hand, making the system more efficient by doing everything electronically means that along the way we have to be very careful to build in the kind of antifraud safeguards that exist in many individual organizations, computerized detection systems.

Those are the principal points I wanted to highlight, and I will be happy to answer any of your questions.

[The prepared statement follows:]

STATEMENT OF WILLIAM J. MAHON, EXECUTIVE DIRECTOR, NATIONAL HEALTH CARE ANTI-FRAUD ASSOCIATION

Mr. Chairman, Members of the Subcommittee.

My name is Bill Mahon. I am Executive Director of the National Health Care Anti-Fraud Association—NHCAA—which appreciates the opportunity to offer testimony on the nature and impact of what increasingly is acknowledged to be a national crime problem of genuinely alarming proportions.

We commend you, Mr. Chairman, and your Subcommittee colleagues for your attention to this problem and your desire to address it more forcefully.

Established in 1985 by seven commercial health insurers, one state Blue Shield plan and several individuals from public-sector law enforcement agencies, NHCAA is a unique organization that combines the anti-fraud efforts of the private-sector health insurance industry with those of the public-sector administrative and law enforcement agencies responsible for investigating and prosecuting health care fraud. As such, NHCAA is not a trade association, nor is it a lobbying organization. Rather, it is an issue-based cooperative association whose member organizations account for most of the private and public health insurance benefits paid in the US, and whose objective is to improve the private and public sectors' ability to detect, investigate, prosecute (both civilly and criminally) and, ultimately, prevent health care fraud.

From the private sector, NHCAA numbers 45 commercial and not-for-profit insurers as Corporate Members; the public-sector members of the Association's Board of Governors are: the Chief of the White-Collar Crime Section of the Federal Bureau of Investigation; the Deputy Inspector General for Investigations and the Assistant Inspector General for Civil Monetary Penalties of the Office of Inspector General of the Department of Health and Human Services; the Assistant United States Attorney and Chief of the Civil Division for the Eastern Pennsylvania District of the Department of Justice; the Director of the Florida Medicaid Fraud Control Unit; the Medicaid Fraud Counsel of the National Association of Medicaid Fraud Control Units; and, most recently, the Deputy Director of the Office of Medicare Benefits Administration in the Bureau of Program Operations of the Health Care Financing Administration, responsible for monitoring and coordinating HCFA's fraud and abuse detection and deterrence program.

Beyond its Corporate and Public-Sector Board membership, NHCAA also numbers 480 Individual Members, from member and non-member insurers, from self-insured corporations and from a wide variety of other state and federal law enforcement organizations, such as the Defense Criminal Investigative Service, the Office of Personnel Management, the Postal Inspection Service, and state attorneys generals' offices.

NHCAA pursues its overall objective in a variety of very specific ways: (1) by serving as a vehicle for ongoing education in the specifics of health care fraud detection, investigation and prosecution; (2) by serving as a mechanism through which private payors and law enforcement organizations share information on health care frauds (with appropriate legal safeguards); (3) by providing a professional network through which members can learn and benefit from each others' expertise and experience; and (4) by informing the public, the media and government about the nature of the problem and its impact on our society.

The intensity with which attention to health care fraud continues to increase has been manifested dramatically in NHCAA's membership and activities. Between January 1992 and today, for example, the Association's Corporate Membership more than doubled to its present number; and attendance at our annual educational conference has increased by 30% in each of the last two years, most recently to a total of 544 in November 1992.

Paralleling that growth, and highlighting the distinct value of NHCAA's unique private-public makeup, is the increasing frequency with which the Association is called on in an educational and advisory capacity by Congressional committees, state governments and various federal government offices. In recent months, for example, we have worked with the Justice Department, the Office of Inspector General at Health and Human Services, the FBI and other organizations as part

of a group convened first by the Office of Management and Budget and again by the Presidential Transition office to discuss health care fraud and the development of more effective means of dealing with it.

Health care fraud is by no means a "victimless" white-collar crime. On the contrary, its victims are all of us here this morning, along with our 250 million fellow citizens who ultimately pay the price for health care in the United States—as individuals who pay health insurance premiums, co-payments and deductibles; as businesses who purchase health coverage for their employees (and who represent a key constituency for our efforts); and as taxpayers (where we are in fact twice victimized) when Medicare, Medicaid and other government payment programs are the targets of fraud.

Health care fraud takes a wide variety of forms. It runs the gamut, from individual providers who routinely fabricate or knowingly inflate or otherwise misrepresent claim information in order to receive third-party payments to which they are not entitled—or higher payments than they would otherwise receive; to health care supply businesses that prey on the Medicare program and other payors and attempt to make both physicians and beneficiaries unwitting accomplices in schemes that result in fraudulent billing for millions of dollars worth of medical equipment and supplies; to entities such as "rolling lab" schemes established solely as vehicles for committing fraud within the health care arena; to institutional frauds by hospitals, laboratories and clinics, all or part of whose basic business operation revolves around the systematic commission of fraud.

What these various schemes have in common is the criminal and quite deliberate intention to defraud [see Appendix I, *NHCAA Guidelines to Health Care Fraud*]. As such, we must emphasize our belief that they represent the actions of only a very small proportion of health care providers and others in the field. Unfortunately, though, given the enormous amount of money at play in our health care system, the actions of even a tiny dishonest minority can inflict massive financial damage on both private and public payors. Last year, for example, an Florida physician and his spouse were sentenced to prison after pleading guilty to having filed more than $800,000 in false claims with private payors and Medicare. In another recent case, a clinical laboratory firm pled guilty to filing fraudulent claims and will pay the federal government and several state Medicaid programs a total of more than $110 million. Meanwhile, the largest alleged scheme identified to date—the California rolling lab case—is alleged to have filed nearly $l billion in false claims during the 1980s.

How much do we lose in all? By its nature, the amount lost to any ongoing fraud can never be quantified to the exact dollar and thus must be estimated in an "educated" context. In that context, the members of the NHCAA Board of Governors estimate the loss to outright fraud at between 3% and perhaps as much as 10% of what we spend as a nation on health care each year. In 1993, then, with our total health care expenditure projected to be $939.9 billion, we estimate a loss to outright fraud of at least $28 billion—and perhaps as much as $94 billion. Other estimates place the extent of the loss at even higher totals, but by even the most conservative gauge, it is clear that we are losing many billions of dollars each year.

In this context, we must note that that enormous loss is shared in roughly equal proportions by both the private and public sectors. The Health Care Financing Administration, for example, has indicated that of the nation's total health care bill, 37% is paid by private insurers and 19% by consumers through out-of-pocket payments—for a total of 56%. This private-sector exposure indeed is one rationale for the more aggressive federal initiatives of recent years, and it must be taken into account in the course of creating additional anti-fraud measures.

How are such losses possible?

First, and as a general observation, they stem from the efforts of a small proportion of individuals to defraud a system that, resting on an assumption of honesty, is geared to pay health care claims efficiently and—often by statute—more and more rapidly than ever before. In that context, claims payers find

themselves trying to meet demands that at best are not easily reconciled: i.e., to pay claims faster and faster, AND to put a stop to fraud in the system.

Putting a stop to a given fraud means first identifying it as a potential fraud through one or more of the various means employed for that purpose; conducting an investigation with regard for due process; in the private sector, involving law enforcement and prosecutorial authorities; and in the case of criminal prosecutions, proving criminal intent to defraud.

The identification of potential fraud is itself no easy matter, in that a given claim that meets all requirements of form and content—but is purely fictitious—cannot be identified as such on the face of it. Rather, it is when such claims become apparent as part of a given pattern, or when a beneficiary or other individual has called the payor's attention to them suggesting impropriety, that they become suspect.

In addition, rarely does a provider engaged in fraud victimize only one insurer or program. Experience tells us that the same provider who is defrauding Medicare is in all likelihood defrauding the private sector—and vice versa. In that context, a provider will generally spread his or her fraudulent-claims activity among any number of payors—the better to remain inconspicuous and thus prolong the detection process with each.

The investigation and prosecution processes also present the private-sector with a number of obstacles, both real and perceived. First, what is a crime when aimed at a federal program is not always illegal when aimed at private payors: the payment of "kickbacks" for referral business that has a snowball effect on the volume of claims; or the waiver of the patient's insurance co-payment when used systematically as a "free service" marketing "hook" with which to lure patients into fraudulent-billing schemes.

Second, insurers bringing cases for prosecution often are confronted with the very real hierarchy of prosecutors' priorities, in which health care fraud cases must be weighed according to their nature and financial dimensions. (The Justice Department's more recent initiatives to place a much higher priority on these cases, and its efforts to work much more closely with the private sector on the investigative and prosecutorial levels are extremely well received and will benefit all concerned.)

Third, insurers conducting investigations and bringing cases in good faith do so in an environment of widely varying degrees of potential civil tort liability to the subjects of those investigations. In some states, insurers enjoy relatively strong civil immunity protection in such investigative information-sharing and reporting activity; in others, they enjoy no such protection at all. In that context, they must continually consider the reality of probable lawsuits—at best costly, even if without merit—on such grounds as defamation and/or malicious prosecution in pursuing fraud cases.

Another reality in today's anti-fraud environment is the uncertainty that a successful prosecution will result in recovery or restitution of funds lost to the fraud. The absence of such reasonable assurance represents yet another factor that insurers must weigh in pursuing a given case.

These many realities notwithstanding, the member organizations of NHCAA have long been committed—practically and philosophically—to the aggressive pursuit of health care anti-fraud activities. Both through our formal activities and via the professional interaction that stems from their membership, those organizations' anti-fraud programs realize a tangible return on their investment in the Association. However, their philosophic readiness to do more will be greatly complemented by the practical provision of more effective tools with which to do so.

In closing, we must look to the future, in which both the broader application of the "managed care" delivery model and all-electronic processing of insurance claims are widely cited as two evolutionary developments that are among the answers to the nation's health care cost and delivery questions. Effective measures against

fraud must be incorporated into any such "answers" in order to maximize the benefits of fighting health care fraud.

Again, Mr. Chairman, NHCAA appreciates your attention to health care fraud and looks forward to continuing to contribute to the development of more effective measures to combat the problem.

Mr. LEVIN. Thank you.

Mr. Anderson, from me, since you are from Michigan, a special welcome.

Glad to see you, both of you.

STATEMENT OF GREGORY ANDERSON, DIRECTOR, CORPORATE AND FINANCIAL INVESTIGATIONS, BLUE CROSS AND BLUE SHIELD OF MICHIGAN, ACCOMPANIED BY CHARLOTTE BARTZACK, DIRECTOR, MEDICARE FRAUD AND ABUSE UNIT

Mr. ANDERSON. Mr. Levin and members of the committee, I would like to read a summary of my testimony in the record.

I am Greg Anderson, director of the Corporate Financial Investigations Department of Blue Cross and Blue Shield of Michigan. We appreciate this opportunity to discuss an issue of great importance, fraud and abuse.

As part of our commitment to deliver health coverage in the most affordable manner possible, we established the corporate and financial investigations department in 1980 to detect, investigate and seek prosecution of fraudulent activities related to our private health insurance business. It was the first fraud unit of its kind in the country.

We are very aggressive, and have developed legislation to help us combat health care fraud in Michigan. Since 1980, Blue Cross and Blue Shield of Michigan has saved or recovered more than $103 million through the fraud investigations unit.

We have had 1,539 referrals to law enforcement, 960 warrants issued and 670 convictions. We currently have 2,000 open investigations.

We receive leads on potential fraud from a number of sources. However, we rely primarily on our toll-free, antifraud hot line, which receives up to 18,000 calls per year. Nearly one-third of these tips result in an investigation.

We encourage local newspapers and television news programs to broadcast the hot line telephone number. The hot line number is also listed on the Explanation of Benefits form, or EOB, that each subscriber receives after medical services are rendered.

In addition to the hot line, we also use an automated computer system that does overall physician monitoring and identifies potential fraud and abuse cases for us. A similar system reviews drug utilization. Because of the success of our unit, we also receive a large number of referrals from law enforcement agencies.

We use a variety of investigative techniques to substantiate fraud leads, including computer analysis, surveillance, undercover visits to providers, patient interviews, medical reviews and the use of informants. Once we have substantiated a fraudulent activity, we refer the case to the appropriate law enforcement agency and

continue to assist in the investigation throughout prosecution by a local prosecutor or U.S. attorney. This includes courtroom testimony.

In an effort to maximize the limited resources that are available to combat fraud and abuse, we often use a task force approach involving State, Federal, and local authorities to investigate and prosecute fraud.

We also participate in quarterly law enforcement meetings—including the State Medicaid fraud units, the FBI, the Michigan State Police, the U.S. Attorney's office, the Department of Licensing and Regulation, as well as the Federal Drug Enforcement Administration. These meetings provide a forum to exchange information on current cases and facilitate the development of joint investigations that address private insurance, as well as Medicare and Medicaid.

We work with and rely on the court system to order restitution, including our investigative expenses, following convictions. However, if restitution is not ordered, we pursue recovery in the civil arena.

Providers convicted of health care fraud are departicipated from Blue Cross and Blue Shield of Michigan, meaning that the provider can no longer be directly reimbursed for services rendered to subscribers. We also inform the Department of Licensing and Regulation of the fraudulent activity.

As Medicare contractors, we also have important responsibilities in detecting and preventing fraud and abuse. Beneficiaries frequently bring cases to our attention by informing us when Medicare has been billed for services that they did not receive. More often, our payment safeguard operations lead us to suspect instances of wrongdoing which are then investigated further.

Last year was the first year that the administration proposed a separate budget of $24 million for the fraud detection efforts of Medicare contractors. As a result of the new funding available and the HCFA mandate, Blue Cross and Blue Shield of Michigan established a dedicated Medicaid Fraud Unit in 1992. Since the units's inception, a toll-free hot line has been installed.

We have been involved in fraud convictions in most sections of the health care industry. I would like to take a moment and share an example of one of the most diabolical schemes.

A defendant in another case tipped us off that controlled substances were being dispensed by a podiatrist. A quick drive by his office substantiated this claim. There were literally lines of people waiting outside his office to go inside.

This Detroit podiatrist generated three-quarters of a million dollars through a conspiracy that included Blues' subscribers and pharmacies. The podiatrist would use runners, that is a sort of street salesman, to encourage subscribers to visit a podiatrist. The podiatrist would then subject the subscribers to hundreds of unnecessary diagnostic and surgical services for which he would bill. I use the term "surgery" loosely, since the podiatrist's only intent was to create a scar. He believed that as long as he performed surgery of a sort, he would be untouchable by fraud charges. His definition of surgery was to pierce the skin and sever the tendon that controls the toes.

In return, the subscriber would receive a prescription for a controlled substance. Dilaudid, a synthetic form of heroin, and Percodan were the most popular. They sell on the streets for $25 to $50 per pill.

The prescription would then be filled at a local pharmacy that was friendly to the operation. The drug store would charge the subscriber cash, as well as bill the insurance company, including billing for an expensive antibiotic that was never actually dispensed.

The original runner and the subscriber would then divide the drugs for personal use or street resale.

Our primary investigative technique in this case involved surveillance to identify the runners. We then made undercover drug purchases from the runners who in return introduced us to the podiatrist. Eventually the podiatrist issued illegal prescriptions to one of our undercover operatives.

Ultimately, the podiatrist pleaded guilty and was sentenced to 10 years in prison. He paid restitution, was departicipated from the plan and had his license revoked.

Although we have successfully detected and prosecuted many fraudulent schemes, we and other Blue Cross and Blue Shield plans across the country have encountered a number of obstacles that inhibit our antifraud efforts. We face increased exposure to liability, even in the course of good-faith fraud investigations, and even after winning a fraud conviction we have no clear right to restitution.

Also, the potential financial reward for health care fraud often outweighs its potential risks. Legislation providing for stiffer penalties in health care fraud cases and the forfeiture of assets derived from the fraudulent activity might help deter fraud by increasing the risks associated with it.

Once again, I would like to thank you for the opportunity to testify on this important issue of fraud and abuse and to reiterate the Blue Cross and Blue Shield system's commitment to comprehensive health care reform.

I would be happy to answer any questions you may have.

[The prepared statement follows:]

STATEMENT OF GREGORY ANDERSON, DIRECTOR, CORPORATE AND FINANCIAL INVESTIGATIONS, BLUE CROSS AND BLUE SHIELD OF MICHIGAN

Mr. Chairman and Members of the Committee, I am Gregory Anderson, Director of the Corporate and Financial Investigations (CFI) Department of Blue Cross and Blue Shield of Michigan. I appreciate this opportunity to discuss an issue of great importance to Blue Cross and Blue Shield Plans in general, and my Plan in particular -- fraud and abuse.

Blue Cross and Blue Shield of Michigan (BCBSM) has offered protection to Michigan residents for over 50 years and currently covers over four million subscribers. We also contract with the Health Care Financing Administration to handle the day-to-day administration of the Medicare Part A and Part B programs.

As part of our commitment to deliver health coverage in the most affordable manner possible, the Corporate and Financial Investigations (CFI) department was established in 1980 to detect, investigate and seek prosecution of fraudulent activities related to our private health insurance business. It was the first fraud unit of its kind in the country. I have been Director of the department since 1984.

Prior to my employment with BCBSM, I worked as a Detective Sergeant with the Michigan State Police where I specialized in Undercover Narcotics, Murder for Hire, Special Homicide Investigations and Executive Protection.

What results has the fraud unit produced?
We recently estimated that Blue Cross and Blue Shield of Michigan has saved or recovered more than $103 million through the fraud investigations unit since the unit's establishment in 1980. We have investigated 10,610 allegations during the past 12 years and have referred 1,539 cases to law enforcement agencies. The evidence we have developed for these cases have resulted in 960 warrants, 867 arrests and 670 convictions.

How do we fight fraud?
Our 29 person department includes 17 investigators who develop and prosecute cases involving fraud. About half our staff comes from law enforcement backgrounds including organized crime, surveillance, consumer fraud, check/credit card fraud, undercover operations and financial investigations. The remainder of the staff come from various other backgrounds including nursing and accounting to help balance the team's expertise.

CFI receives leads on potential fraud from a number of sources. However, we rely primarily on our toll-free anti-fraud hotline which operates during normal business hours and receives up to 18,000 calls per year. Nearly one-third of these tips result in an investigation and the remainder are referred to other areas of the corporation for follow-up. These other calls usually involve minor billing problems or benefit questions.

We encourage local newspapers and television news programs to broadcast the hotline telephone number whenever they report on health care fraud issues. The hotline number is also listed on the Explanation of Benefits or EOB that each subscriber receives after medical services are rendered. The EOB notifies customers of payments made to providers on their behalf and encourages them to contact the hotline if the payments were made in error.

In addition to the hotline, we also use an automated computer system that does overall physician monitoring and identifies potential fraud and abuse cases for us. CFI then joins the BCBSM medical audit team to review these leads and identify those that warrant additional investigation. A similar system reviews drug utilization. Because of the success of our unit, we also receive a large number of referrals from law enforcement agencies. For instance, if they arrest someone in possession of multiple BCBSM cards, the agency would alert us to the situation.

We use a variety of investigative techniques to substantiate fraud leads, including: computer analysis, surveillance, undercover visits to providers, patient interviews, medical reviews and the use of informants. Once we have validated a fraudulent activity, we refer the case to the appropriate law enforcement agency and continue to assist in the investigation throughout prosecution by a local prosecutor or U.S. Attorney, including courtroom testimony. We work with a number of agencies, including the Federal Bureau of Investigations (FBI), the secret service, the Drug Enforcement Agency (DEA) and the Detroit, Michigan, and other local police departments.

We also participate in quarterly law enforcement meetings -- or more often if needed. Participants in these meetings include the State Medicaid fraud units, the FBI, the Michigan State Police, the U.S. Attorney's office, the Department of Licensing and Regulation as well as the DEA. These meetings provide a forum to exchange information on current cases and facilitate the development of joint investigations that address private insurance as well as Medicare and Medicaid. Staff investigators of all of these agencies also have an ongoing working relationship in which they share information daily.

In an effort to maximize limited resources available to combat fraud and abuse, we often use a task force approach involving state, federal and local authorities to investigate and prosecute fraud. This enables us to assure that convicted defrauders will be unable to perpetrate crimes against BCBSM, Medicare or Medicaid in the future.

We work with and rely on the court system to order restitution including investigative expenses, following convictions. However, if restitution is not ordered, we pursue recovery in the civil arena.

Providers convicted of health care fraud are departicipated from BCBSM, meaning that the provider can no longer be directly reimbursed for services rendered to subscribers. We also inform the Department of Licensing and Regulation of the fraudulent activity; they review the provider's case and may impose sanctions such as medical license suspension.

Medicare Fraud Unit

As Medicare contractors, we also have important responsibilities in detecting and preventing fraud and abuse. Beneficiaries frequently bring cases to our attention by informing us when Medicare has been billed for services that they did not receive. More often, our payment safeguard operations lead us to suspect instances of wrongdoing which are then investigated further.

Many of these cases require months of meticulous review in order to validate the alleged instance of fraud. Guidelines developed by the Office of the Inspector General (OIG) are used to refer cases for possible disciplinary action, including financial sanctions or suspension of providers from further Medicare payments.

After the OIG has taken such adverse actions, contractors are required to ensure that no payments are made to the excluded providers according to the terms of judgment. This effort to detect and eliminate fraud, abuse and waste in the Medicare program is a cooperative effort involving beneficiaries, contractors, Peer Review Organizations, State Medicaid agencies, and the OIG.

Our primary role is to identify instances of suspected fraud or abuse and refer them to OIG for consideration and application of criminal or civil money penalties or administrative sanctions actions. Last year was the first year the Administration proposed a separate budget of $24 million dollars for the fraud detection efforts of Medicare contractors. We support this increased emphasis on detecting fraud and abuse in the Medicare program.

As a result of the new funding available and a HCFA mandate, BCBSM established a dedicated Medicare Fraud Unit in 1992 that includes 23 full time employees and two part-time investigators. Since the unit's inception, a toll-free hotline has been installed to receive tips on potential fraudulent situations. This hotline is separate from the one used for our private business.

We have also established a wide network with the aging population through such agencies as the "Senior Alliance", "Agencies on Aging", AARP, and the Michigan Offices of Services to the Aging. Finally, we are distributing information on fraud and abuse to the provider community through our regular Medicare publications and through many training seminars and public speaking events.

Last month, the GAO again recommended altering the BEA to allow funding of contractor activities that save taxpayers' money by recouping overpayments and denying payment for medically unnecessary services. GAO reported that tight budget caps prevent the level of investment needed in payment safeguard activities even though they consistently save taxpayers much more than they cost. We strongly agree with GAO's proposal and urge that the budget change apply to the full scope of Medicare contractor activities.

Legislation recently introduced by House Ways and Means Committee Chairman Rostenkowski (H.R. 21) would accomplish the budget reform objectives recommended by GAO. These budget reform proposals would allow Medicare administrative activities funding up to a specified maximum amount each year. Budget spending caps would then be adjusted for appropriations provided within this limit. The Rostenkowski legislation would allow Medicare contractor funding to increase by up to 11.6 percent each year under the special adjustment and would enable the Appropriations Committees to provide an adequate level of funding for Medicare administration without violating the restrictive budget caps. In our view, the enactment of this legislation would make a major difference providing needed funding for a more comprehensive management approach for the entire Medicare program.

Fraud Schemes are Intricate and Ingenious: One Example
As Director of CFI, I have worked on a multitude of fraud cases encompassing virtually all specialty health care sectors -- pharmacy wholesalers, durable medical equipment companies, and chiropractors to name a few. I would like to share an example with you of the diabolical cleverness of these schemes.

A Detroit podiatrist generated three-quarter of a million dollars in unnecessary billings to BCBSM through a conspiracy that included BCBSM subscribers and pharmacies. The podiatrist would use "runners" -- that is, a sort of street salesman -- to convince BCBSM subscribers to visit the podiatrist in return for drugs or money. The podiatrist would then subject the subscriber to hundreds of unnecessary diagnostic services or "soft tissue surgery" for which he would bill BCBSM. I use the term surgery loosely since the podiatrist's only intent was to create a scar to help disguise the scheme. He believed that as long as he performed surgery of a sort, he would be untouchable by fraud charges. His definition of surgery was to pierce the skin and sever the tendon that controls the toes, a procedure he considered harmless.

In return, the subscriber would receive a prescription for a controlled substance. Dilaudid, a synthetic form of heroin, and Percodan were the most popular; these addictive drugs sell on the street for $25 to $50 per pill.

The prescription would then be filled at a local pharmacy that was friendly to the operation. The drug store would charge the subscriber cash as well as bill the insurance company. Generally, the pharmacy would also bill BCBSM for an expensive antibiotic that was never actually dispensed.

The original runner and the subscriber would then divide the drugs for personal use or street resale. The subscriber then had the option of becoming a runner and recruiting another BCBSM subscriber into the conspiracy. Each runner who brought in five new subscribers received a bonus prescription of say, 30 Dilaudids.

The scheme was ingenious because it was a closed loop where each participant -- runners, subscribers, pharmacies -- received something for nothing and therefore had an incentive to keep quiet about the conspiracy.

However, a defendant in another BCBSM case turned informant and tipped us off that controlled substances were being dispensed by this podiatrist. A quick drive by his office substantiated the claim -- there were literally lines of people outside his office waiting to go inside.

Our primary investigative technique in this case involved surveillance to identify the runners. We then made undercover drug purchases from the runners who in return, introduced us to the podiatrist. Eventually the podiatrist issued illegal prescriptions to one of our undercover operatives.

Ultimately the podiatrist pleaded guilty and was sentenced to ten years in prison. He paid restitution to BCBSM, was departicipated from the Plan and had his license revoked.

Other Fraud Unit Activities

In addition to addressing fraud within our Plan, we also recognize the importance of educating the public and law enforcement agencies on health care fraud. We have an ongoing program with the FBI in planning their health care fraud investigative strategies as well as training agents in the intricacies of medical fraud investigations. We are involved in similar educational activities with the Michigan State police department, the Oakland County Detectives Association, the Macomb County Detectives Association as well as other local prosecutors and police agencies.

Obstacles to Detecting, Prosecuting and Recovering Losses from Fraud

Although we have successfully detected and prosecuted many fraudulent schemes at BCBSM, we and other Blue Cross and Blue Shield Plans across the country have encountered a number of obstacles that inhibit our anti-fraud efforts. For instance, we face increased exposure to liability even in the course of good-faith fraud investigations. For example, liability suits, though unjustified, may be filed:

- if we delay payments to allow additional time for investigation and research into the legitimacy of a claim;

- if we disclose certain patient-identifiable information to appropriate authorities in the course of an investigation -- even with continued privacy protection for the patient;

- if we refer suspected criminal activities to appropriate authorities, or;

- if we share information and cooperate with other appropriate, interested parties in a fraud investigation.

In addition to the increased liability exposure, we have no clear right to restitution from parties convicted of criminal offenses. I believe that any anti-fraud legislation should provide appropriate protections from increased exposure to liability when we pursue, in good-faith, activities in connection with the detection, prevention and prosecution of health care fraud, and should facilitate our recovering monetary losses due to fraud.

Also, the potential reward for health care fraud often outweighs its potential risks. Legislation providing for stiffer penalties in health care fraud cases and the forfeiture of assets derived from the fraudulent activity might help deter fraud by increasing the risks associated with it.

Closing Remarks

In conclusion, I would like to emphasize that fraud and abuse poses a very real, and very expensive problem for all Americans, whether they are privately insured or receive coverage through Medicare and Medicaid. Problems with fraud and abuse will continue to persist, no matter what form of health reform is adopted, unless these issues are addressed within the context of overall, comprehensive reform.

The Blue Cross and Blue Shield system supports comprehensive reform of the health care system that builds upon the strengths of the workplace-based, private, multi-payer system.

Once again, I would like to thank you for the opportunity to testify on the important issue of fraud and abuse and to reiterate the Blue Cross and Blue Shield system's commitment to comprehensive health care reform. I would be happy to answer any questions you may have.

Chairman STARK [presiding]. Thank you.
Dr. Schenken.

STATEMENT OF JERALD R. SCHENKEN, M.D., MEMBER, BOARD OF TRUSTEES, AMERICAN MEDICAL ASSOCIATION

Dr. SCHENKEN. Thank you, Mr. Chairman. Mr. Chairman, the vast majority of physicians and AMA Members are conscientious, caring and honest. I am here to represent them.

As for the rest, the unethical and the fraudulent, I am here to offer you my help, as well as the help of the AMA, to rid the profession and the Nation of this plague upon both our houses. The fact that many, if not most, fraudulent operations are not run by physicians at all further complicates our problem.

We support the establishment of an intergovernmental commission to further investigate the nature, magnitude and costs involved in health care fraud and abuse. In addition, we strongly urge that a clear definition of, quote, health care offense, unquote, be incorporated into any proposal. Health care fraud and abuse is currently prosecuted under both the mail and wire fraud statute, as well as the Medicare law. These two provisions must be reconciled in any approach that is ultimately formulated.

The AMA urges that any definition of health care offense include knowing, willful and fraudulent intent on the part of the health care professional or provider. We believe that billing errors and most utilization concerns do not constitute fraud.

Such issues, instead, relate to the practice patterns of physicians and would be better addressed through practice guidelines and peer review mechanisms. Thus, the parameters of fraudulent practices must be clearly articulated.

The same general statement was made by the FBI at a recent judiciary hearing in which I was privileged to participate. Ours is a profession that relies on public and individual patient trust as a vital element in providing successful medical care. Clearly, any number of bad apples is too many.

The AMA is already pursuing a number of antifraud activities. For example, AMA officials have assisted the FBI and training agents to ferret out fraud. We have also offered our network of State medical and national specialty societies, boards and other entities with self-regulatory mechanisms in place to combat criminally fraudulent activities. Unfortunately, law enforcement alone will not create an environment in which fraudulent and wasteful activity will become only a marginal concern. Individuals must be involved as well.

Mr. Chairman, it is clear that bills for medical services are often not sent to patients who could identify fraud, at least for services billed, but not provided. And you have heard about those today. A golden opportunity is missed. Many businesses and insurers are currently asking patients to review such bills.

Mr. Chairman, the AMA has filed a petition with the Federal Trade Commission seeking to remove limitations that restrict the medical profession from pursuing additional efforts to discipline itself. We also support H.R. 47, which would provide an exemption from the Federal antitrust laws for medical self-regulatory entities engaged in enforcement activities designed to promote the quality

of care. Such an exemption would enable the medical profession to play a more active role in the elimination of health care fraud and abuse.

Mr. Chairman, it is difficult to overemphasize the importance of this initiative as part of our efforts.

Let me make one point clear. If our initiatives are viewed by physicians as effective in rooting out fraudulent practitioners, fraudulent physicians when they are involved, and true hustlers and charlatans, and at the same time are fair to conscientious physicians who make unintentional billing errors, you will have our enthusiastic support.

If, however, the bill, the enforcement mechanisms or the regulations appear to harass legitimate practitioners more and convict criminals less, professional support will wane. I am sure this is not your intention. The AMA must and will work with you to make sure this does not happen.

Mr. Chairman, the AMA appreciates the opportunity to appear before the subcommittee. I would be pleased to respond to any questions you and the other committee members might have. And I thank you.

[The prepared statement follows:]

STATEMENT

of the

AMERICAN MEDICAL ASSOCIATION

to the

Subcommittee on Health
Committee on Ways and Means
United States House of Representatives

Presented by

Jerald R. Schenken, MD

RE: Health Care Fraud and Abuse

March 8, 1993

Mr. Chairman and Members of the Subcommittee:

My name is Jerald R. Schenken, MD. I am a pathologist from Omaha, Nebraska and a member of the Board of Trustees of the American Medical Association (AMA). Accompanying me is Hilary Lewis, JD, of the Association's Division of Federal Legislation. On behalf of the AMA, I want to express our appreciation for the opportunity to appear before the Subcommittee to provide our views on the subject of health care fraud and abuse.

While the scope of this problem is clearly substantial, its precise dimensions remain difficult to quantify. One point, however, must be emphasized: whatever resources are expended for fraudulent and wasteful practices diverts the use of funds and efforts from meeting legitimate health care needs. The AMA urges that activities be undertaken to identify and eliminate abusive, wasteful and fraudulent practices.

COST OF HEALTH CARE FRAUD

In order to effectively address the issue of health care fraud, its proportions and magnitude must be accurately identified. A May 1992 study issued by the General Accounting Office (GAO) declares that "health industry officials estimate that fraud and abuse contribute some 10 percent to $700 plus billion in U.S. health care spending." A more recent GAO study, issued in December 1992 on fraud and abuse in the processing of Medicare claims, states that Medicare's losses cannot be quantified precisely and observes that "health industry experts estimate that fraud and abuse could account for as much as ten percent of the nation's total health care costs."

The AMA believes that more rigorous scrutiny must be brought to bear regarding the existing nature and amount of health care fraud. Only careful examination of its scope will ultimately yield the most effective solutions to this difficult problem. Further information is needed.

In an effort to identify areas of fraudulent practice, the AMA would be pleased to work with the federal government in studying the extent to which health care fraud permeates the current environment. Our own survey data, for example, have elicited valuable information on the incidence of hospitals that require physicians to make payments for hospital services. In our study, physicians were asked: (1) whether any hospital had ever requested the physician (or the physician's practice) to make payments to the hospital for the privilege of serving patients there; and (2) whether the physician had ever been asked to make payments to a hospital for the privilege of utilizing space, supplies, equipment, utilities, hospital employees, or billing information. (See Attachment A.) In our view, the proper development of similar data on other possible abuses that are present within our health care system will result in the development of the most effective solutions to this problem.

We strongly concur with the recommendation issued by the GAO in the May 1992 study that calls for the establishment of a national commission to develop comprehensive solutions to health insurance fraud and abuse. We also support the recommendation in the December 1992 GAO study advocating a nationally coordinated effort to combat fraud and abuse.

LEGISLATIVE APPROACHES

We commend you, Mr. Chairman, and the Subcommittee, for examining the critical issue of health care fraud and abuse.

The AMA believes that any legislative solution that is formulated must contain a number of elements. First, we support the establishment of an intergovernmental commission to investigate the nature, magnitude and costs involved in health care fraud and abuse.

Second, we strongly urge that a clear definition of a "health care offense" be incorporated into any proposal that is considered. Health care fraud and abuse is currently prosecuted under sections 1341 and 1343, Title 18, United States Code, the mail and wire fraud statute, as well as under Title 42, Medicare. These two provisions must be reconciled in any approach that is formulated in order to: (1) attain consistency; (2) preclude harsh sanctions for inadvertent or legitimate mistakes, such as billing errors; and (3) impose penalties commensurate with the offense that is committed.

While a physician is, of course, responsible for actions performed in his or her name, the physician should be found to be acting with the intent to commit a fraudulent act where a court imposes a severe sanction. To address this, we urge that any definition of a "health care offense" include knowing, wilful or fraudulent intent on the part of a health care professional or provider. It will, therefore, be necessary to amend more than the mail and wire fraud statutes in order to achieve this purpose. If the Criminal Code, Title 18, is used as the primary vehicle for prosecution of health care fraud and abuse in furtherance of Medicare (Title 42) offenses, fines and imprisonment exceeding the gravity of the offense will result. The AMA, therefore, advocates legislation prescribing penalties in accordance with Medicare's violations. We strongly discourage, moreover, any effort to impose a prosecutorial scheme on the health care industry bearing the indicia of a RICO-type statute with draconian penalties disproportionate to the offense committed. Fraudulent health care practices may be better ameliorated through the creation of legal means other than the blueprint now in place to fight organized crime.

As outlined below, the AMA also favors the award of grants to medical societies for the creation of programs to address fraud and abuse.

ETHICAL ISSUES

Where a physician provides care in a fraudulent manner, numerous ethical breaches occur, and the AMA has addressed these matters through various ethical pronouncements. These statements require ethical physicians to accept the responsibility to report colleagues who are engaged in fraud or deception.

The AMA Principles of Medical Ethics state, as follows:

> A physician shall deal honestly with patients and colleagues, and strive to expose those physicians deficient in character or competence, or who engage in fraud or deception.

Opinion 9.031 of the AMA's Council on Ethical and Judicial Affairs (CEJA) outlines the physician's obligation to report impaired, incompetent, and unethical colleagues in accordance with the legal requirements in each state pursuant to the guidelines outlined in the opinion. With respect to the reporting of unethical conduct, the opinion specifically states:

Unethical conduct that threatens patient care or welfare should be reported to the appropriate authority for a particular clinical service. Unethical behavior that violates state licensing provisions should be reported to the state licensing board. Unethical conduct that violates criminal statutes must be reported to the appropriate law enforcement authorities. All other unethical conduct should be reported to the local or state medical society.

Where the inappropriate behavior of a physician continues despite the initial report(s), the reporting physician should report to a higher or additional authority. The person or body receiving the initial report should notify the reporting physician when appropriate action has been taken. Physicians who receive reports of inappropriate behavior have an ethical duty to critically and objectively evaluate the reported information and to assure that identified deficiencies are either remedied or further reported to a higher or additional authority. Anonymous reports should receive appropriate review and confidential investigation.

AMA INITIATIVES AND RECOMMENDATIONS

The AMA recognizes that additional efforts must be undertaken to attack health care fraud and abuse, especially inasmuch as it transcends the medical profession, reaching into many segments of our society. Unfortunately, people and entities from all walks of life have been found culpable in contributing to the magnitude of the problem.

The medical profession remains committed to rendering high quality medical care to its patients on an ongoing basis, and the AMA is proud of the work of our professional community. While some physicians have been implicated in health care fraud activities, we note that their numbers have been minimal. Even this level of physician participation is unacceptable, and the AMA does not condone fraudulent activity on the part of even one individual. In a profession that relies on public and individual patient trust as a vital element in providing successful medical care, any number of "bad apples" is too many.

The AMA stands ready to assume an active role in identifying those who would profit by improper use of their authority to practice medicine. We pledge to work with the Congress and appropriate law enforcement agencies in a cooperative endeavor to attain the goal of eliminating health care fraud in all of its forms. To this end, the AMA is pursuing a number of activities.

I. Cooperation with Federal Bureau of Investigation (FBI)

In 1992, representatives of the AMA met with the Federal Bureau of Investigation to discuss issues relating to fraud and abuse. Throughout this very constructive session, FBI representatives made it clear that physicians are not responsible for the vast majority of health care fraud and abuse. The AMA, however, does not take comfort from the fact that the number of physicians who seek to gain through fraudulent practices is small.

We have agreed to provide assistance to the FBI in a cooperative endeavor as it attempts to identify and prosecute health care fraud. AMA officials have assisted the Bureau in training agents to ferret out fraud. We have also offered our network of state and specialty societies, boards and other entities to combat criminally fraudulent activities. The self-regulatory mechanisms of these organizations should be useful in detecting illegal activity.

2. AMA Fraud and Abuse Hotline

The AMA has committed resources to establishing a system whereby medical societies or individual physicians can report fraud through the AMA by dialing our toll-free member services number. After receiving such a call, the AMA will contact sources at the FBI to report the matter. We have notified state and county medical societies of this activity and requested that it be publicized to their membership. The Association has also stressed that physicians should report any invitation to engage in fraudulent activity.

3. Health Care Commission on Fraud and Abuse

While more criminal investigations by the FBI, the Inspector General and the states will succeed in eliminating some of the immediate problem, law enforcement alone will not create an environment in which fraudulent and wasteful activity will become only a marginal concern. Even a cursory examination of the "war on drugs" illustrates this point. As stated earlier, the most effective initial step will include accurate identification of the dimensions of health care fraud and abuse so that investigatory resources may then be focused in a manner that will address the causal agents and not merely the isolated criminals.

The establishment of a national commission on fraud and abuse would be beneficial, as it could explore mechanisms to facilitate fraud detection, such as allowing health benefit plans to exchange information for coordinating prosecution efforts and to ensure the availability of appropriate and effectively applied resources to law enforcement authorities to combat fraud and abuse. However, any measures taken must proceed cautiously, as even seemingly innocuous actions, such as information exchange systems and other investigatory activities, must be carefully weighed against potential sacrifices of patient confidentiality protection. Through careful consideration of such concerns, the commission could provide a valuable means to target and focus activity to address this critical issue.

4. Professional Self-Regulation

The medical community is currently constrained from efforts to discipline itself by state and federal antitrust laws that inhibit the ability of organized medicine to assume an expanded professional self-regulatory and enforcement role. When medical societies have tried to exert their influence on economic matters, even where the issues involve fraud and abuse, antitrust provisions have precluded action. The AMA has recently filed a petition with the Federal Trade Commission (See Attachment B.) seeking to remove limitations that restrict the medical profession from pursuing additional efforts to discipline itself. To this end, the AMA also supports H.R. 47.

We believe that an exemption from the federal antitrust laws for medical self-regulatory entities engaged in enforcement activities designed to promote the quality of health care, which would be created under H.R. 47, would advance progress in this area. It would also enable the medical profession to play a more active role in the elimination of health care fraud and abuse. In addition, statutory immunity should be afforded to those who provide information in good faith leading to prosecution and conviction of health care offenses. Any proposed legislative solution needs to incorporate this approach, and it must be carefully crafted to clearly illuminate the parameters of a fraudulent practice.

5. Medical Society Grants

Another mechanism for health care fraud and abuse detection should include the award of grants to medical societies for the establishment of programs specifically targeted toward this issue. Medical societies presently lack the resources to launch comprehensive initiatives to investigate and study these issues. The majority of their disciplinary activities are directed at problems relative to fee disputes, impaired

physicians or sexual misconduct. An award grant program would better enable medical societies to explore mechanisms to facilitate fraud detection at the local level, work with state medical disciplinary agencies to identify those who commit health care fraud, and ensure that appropriate sanctions are imposed.

6. State Licensing Boards

The state medical and licensing boards, through their authority to license and discipline health care professionals, also have an important role to play in any organized effort to address health care fraud and abuse. The AMA urges the Subcommittee to pursue discussions with the Federation of State Medical Boards regarding possible strategies to achieve the goal of strengthening the ability of state agencies in this regard.

CONCLUSION

In conclusion, the AMA underscores its commitment to eliminate health care fraud and abuse wherever it exists. We welcome the opportunity to work with Congress and others on this issue so that our health care resources may be maximized to focus on our mutual goal -- the provision of quality health care to all of our citizens.

The AMA appreciates the opportunity to appear before this Subcommittee. At this time, we will be pleased to respond to questions.

Chairman STARK. Well, let me start by asking you, Doctor, we have—we will give you copies, if they haven't been distributed, of the bill that Mr. Levin and I are going to introduce which deals more with ranges of possible penalties after investigators have found people commit crimes. Right now it is kind of a cliff.

You are either executed or you are not, and we think that somewhere between, figuratively speaking, execution and wrist-slapping, there ought to be a range of penalties that enforcement people can use to fit the crime, so to speak.

We would like very much to have your concurrence on that. In H.R. 200, the leftover from H.R. 5502, we extended the referral bill to a range of services other than diagnostic laboratories—I think to diagnostic imaging and others—and I would think the next step would be to expand that to all payers. It is now a Medicare law, Medicare/Medicaid, and it is my understanding that—I hate to generalize, but I think the AMA supports the absence of referral fees or kickbacks.

But it would seem to me our help in helping you to define the rules would be a good step. If we could get that much done and find something that private insurers can work with, that State and medical examiners can work with, and that the Federal Government can work with so we are all enforcing the same law, I think we would be on the right road.

Then what I don't know is do you want to hasten a great deal to do much more than that until we figure out how it all fits together. You suggested a commission. My experience on commissions is that they never seem to get much done. I think we have a little piece or two that we could start with and see how it works, how we could get together with Mr. Anderson, with the Blues and other commercial insurers who have a problem.

If every State had as many investigators as you do, you would have probably two or three times what we have just in the IG's office in Medicare. And either we are woefully understaffed or you are delightfully overstaffed, but I think that somewhere with cooperation, we could stop having multiple layers of medical companies out there, that we ought to be able to find some cooperation. But we aren't going to do it unless the doctors will go along with us.

Really, it can't happen without them, so your input and criticism, detailed criticism, of the legislation and how it could be improved is really necessary. I look forward to your input, both in the referral area and in this first attempt to expand the antifraud and abuse to all payers.

We are not going to get it all done on the first bite of the apple, but it seems to me we are going to have to move on, and we need the same kind of help from the commercial companies. There is no sense putting in laws that are going to make their jobs harder.

Dr. SCHENKEN. Yes, Mr. Chairman. In regard to your bill, we certainly agree that the penalty ought to fit the crime, but not having seen it makes it difficult to comment upon, we will certainly work with you on it because it makes general sense.

On the issue of extension to the private sector, the AMA is certainly in general agreement with that. We would want to look at the bill.

One comment on the commission. I am skeptical sometimes on commissions personally myself. However, I think we need to make sure that we don't do some things that have either been tried before and are wasteful, or are done for other reasons. I will give you an example.

For reasons that perhaps your staff is familiar with, pathologists—I happen to be a pathologist by training, and that is what I do—pathologists were just required to change from billing as a group of pathologists, there are 10 pathologists that work with me, to billing as individual pathologists to solve a completely different problem. This would compound the single billing issue.

And I think that we could be very helpful working with you and other people just to make sure that as we go along with the electronic billing, as we get single systems for forms, as we get data that is more uniform, all the things that AMA has long supported, that we make sure that we are going in the right direction. Because, for example, as we have heard from two previous witnesses, not this panel, but before. The issue, the biggest issue is for services that are billed for and not provided, and unless we get either the patient involved in that or in some way somebody else, all this other data isn't going to pickup any of that.

So yes, sir, we would be very pleased to work with you.

Chairman STARK. Thank you very much. As I say, that goes through the private insurers, because they are the other side of the billing structure, for the most part; the person who is paying them and the person who is billing them, we have to somehow be able to work together to see that that is accomplished. I am sorry I missed Mr. Mahon's testimony and the beginning of yours, Mr. Anderson, but I will have the chance to review it.

Mrs. Johnson.

Mrs. JOHNSON. Thank you, Mr. Chairman.

Mr. Mahon, as you are well aware, a number of the big insurers in my State, Aetna, Travelers, CIGNA, Hartford, have all participated in Connecticut's EDI project, and saving millions of dollars in the billing area. But there is a lot of interest in whether or not your association will be part of the electronics and the data systems that will evolve, both for electronic billing and to detect fraud. And while I agree absolutely with Dr. Schenken's comment that you can't, through data systems, necessarily determine whether the care was delivered or not; nonetheless, this issue of involvement by the association, as we go forward on this issue, is a significant one.

Do you have plans to be involved?

Are you working in such a way that you feel confident you will be involved?

Mr. MAHON. I believe it is virtually certain we will be involved. Many of our member organizations are already dealing with EDI implementation in their role as Medicare intermediary carriers to comply with HCFA's mandates for electronic data submission. The prevailing view within our organization's members on EDI is: one, that it is obviously inevitable, the world is moving in that direction; two, that in time, that sort of electronic data bank that builds up should provide for more effective fraud detection, as there is more data with which to work, more bits to compare with whatever systems are brought to bear.

The near-term concern is that as these systems are brought online, as standards are developed for data entry, we not neglect the kinds of technical safeguards that need to be built into whatever electronic system you might devise. Many of our member organizations currently use electronic fraud detection systems. Some are moving beyond those to another generation of artificial intelligence or fuzzy-logic-based software detection systems.

But with so much activity going on, and with the health care system moving headlong into electronic data interchange, we need to be very careful that we don't overlook what can be done to prevent us from turning around 2 years from now and saying "Oh, my God, we forgot about the fraud."

Mrs. JOHNSON. Have any of your members been able to do any research on the amount of fraud that they see or find in capitated systems versus noncapitated systems; or capitated systems versus the selected provider systems? In other words, degrees of closure?

I can't imagine that within a capitated system there wouldn't be markedly less fraud and certainly a dramatic reduction in billing for undelivered services since a capitated system is really the opposite of that.

But even in the networks of selected providers who have been selected on the basis of proficiency in performance and quality, is there any reason to believe that there is less fraud in those kinds of systems as well?

Mr. MAHON. Well, I think the criteria through which you select a handpicked group of providers with whom to deal, for example, gives you a leg up when it comes to eliminating a certain element from your system to begin with. Under that type of system, through whatever contractual agreement you have with these providers, you might also be retaining the right to boot them out of your system if you find they are defrauding you, which is a privilege that you don't enjoy at typical indemnity or fee-for-service plans.

We don't have formal studies comparing degrees of fraud in capitated versus indemnity plans, this sort of thing. Primarily, the nature of fraud dictates that you are estimating your loss based on extrapolations of what you find presently; what you document to be fraud in your system.

There are some assumptions, such as you are making, made about managed care, but it is something, where again, we have to look at how the nature of the fraud might evolve and prepare to deal with that type of fraud.

Mrs. JOHNSON. Do any of the other witnesses have any comment on that, particularly the issue of evidence that fraud is less common in closed systems?

Mr. ANDERSON. Our experience with fraud in managed care at Blue Cross and Blue Shield of Michigan, as far as my investigative facts indicate there is less than the amount of fraud that occurs in the traditional line of business. Again, in managed care programs we have the ability to screen the providers that are involved in these programs and I think that makes a big difference.

You always have the entrepreneurs, though, and at this point I don't think we have had an opportunity to fully investigate all of that.

Mrs. JOHNSON. Thank you.

Mr. ANDERSON. Our experience is there is less fraud in managed care programs.

Mrs. JOHNSON. Thank you, Mr. Chairman.

Chairman STARK. Mr. Levin.

Mr. LEVIN. Thank you.

Mr. Anderson, I took the figures in your testimony about the effect of the unit the last dozen years, you referred 1,539 cases to law enforcement agencies and just roughly extrapolated that over the country. Michigan has, I think, less than 4 percent of the population. You have, what, about 50 percent of the coverage in the State?

Mr. ANDERSON. Approximately that, yes, sir.

Mr. LEVIN. So if you cut 4 percent in half, that is down to 2 percent. If everybody did as well as you did, there would have been 75,000 cases referred to law enforcement agencies the last dozen years in terms of fraud.

My guess is that the number of referrals for fraud in this area would be a fraction of 75,000, and there would have been 33,000 convictions if there were the same experience in other States across the board in terms of insurance.

I think the fact that we have been well short of your rates—I don't know, my guess is we have been nowhere close to 33,000 convictions for fraud in this area—just shows how far we need to go. I think what we need, at first, is a sense of anger about this. For some reason it is more difficult for some in our society to be as angry about this kind of crime as others. I mean, these are not capital crimes and the level of anger understandably will not be nearly as great, but these are serious crimes.

So, actually, I will take your figures and do this kind of rough extrapolation and then see if we can get some figures on what kind of referrals there have been to law enforcement agencies over the last 10, 12 years and what kinds of convictions. Anyway, the testimony of all of you is welcome.

Let me ask you, if I might, Dr. Schenken, and we are so glad you are here today, what do we do about the problem not of claims for services never provided, but for cases where there has been clearly upcoding? Because that is also a part of the fraud on the system. How do we get at that more effectively? I don't mean gray areas but where there has been a clear abuse of the system.

Dr. SCHENKEN. Well, Mr. Levin, currently there are basically two or three issues, Medicare, Medicaid and the private sector, and there are currently various mechanisms.

One of the problems that we currently have is that where the county medical societies or the State medical associations receive a complaint or for some reason get access to this problem, we have effectively been prohibited from getting into that area unless it is fraudulent, unless the State—unless it is up-front fraudulent, unless the particular State law has a reporting requirement. I testified in front of the Judiciary Subcommittee here 2 weeks ago on this issue, and asked them to please look into our requests. We have provided you with a letter we have written to the Federal Trade Commission.

I will give you just an anecdotal experience—anecdotes don't make good laws but they do make good stories—I was chairman of the Ethics and Grievance Committee of our county medical society for 5 years and recently I received a complaint of a bill that was five to seven times as high as the next highest—I called around town to find out what people charged—it was five to seven times as high as the next highest doctor in our community. We were unable to deal with that. It turned out that it came from another State so I had to send it to the State medical association of the other State.

But currently, since these Justice and Federal Trade Commissions' rulings, no county medical societies have felt comfortable dealing with that problem. I am old enough to know that before 1970 we used to deal with it by calling the doctors in and really confronting the situation. I would think about that and upcoding and all of those other matters. Although you will have to deal with them from a regulatory and from a legal standpoint as well, it would be, I think, helpful to us if we had more provisions to deal with it locally, because many times we know more about what is going on locally than other people.

To me, there are a combination of problems. Sometimes it is unclear what the coding should be, and sometimes we are restricted in the private sector from dealing with it, as others have testified.

Mr. LEVIN. Thank you very much.

Chairman STARK. Mr. McDermott.

Mr. MCDERMOTT. Thank you, Mr. Chairman. I want to assure my colleague from Michigan that physicians are probably more enraged by crooks in the profession than anybody else because it makes us all look bad. So I think that you have to understand that most physicians, as Dr. Schenken suggested, are troubled by this.

One of the things, as I listened to the gentleman from Blue Cross in Michigan, I couldn't help wondering, and again anecdotes, single cases don't necessarily make good law, but the question that comes to mind is, in the case where a podiatrist prescribed of controlled substances, did that information ever get provided to the State medical society or to the State disciplinary board or any other mechanism in the State for action?

In the State of Washington, that information would have been provided to appropriate licensing entities. I wonder if that particular practice couldn't have been picked up by another means?

Mr. ANDERSON. Well, today, in Michigan it would have because in 1989, we developed some legislation called triplicate prescription legislation that tracks this type of distribution problem and would have highlighted this particular physician. However we got involved in the investigation relatively early on, probably before he had the opportunity to build up enough practice to tip off investigative agencies at that time.

We had another source that provided us the lead information. Everything was referred to the appropriate licensing boards and the Federal Drug Enforcement Administration, as well, to act on the DEA number, but those were after the fact.

Mr. MCDERMOTT. You made the referral to the licensing board. The DEA did not make the referral?

Mr. ANDERSON. No, no, we did, that is correct.

Mr. McDERMOTT. You made it?

Mr. ANDERSON. Yes, sir.

Mr. McDERMOTT. I would like to hear the four of you discuss the whole issue of the effect of a central data base. If your question is how do you discover billed but unprovided services, does a data base give you a better basis to make that decision to begin screening?

It seems to me that if somebody is screening for the same thing on every patient they see, that should come out in the laboratory billings. It seems to me if you had that kind of data base, where you knew what a doctor's practice patterns were, you would begin to pickup the kinds of patterns which would suggest abuse of the coding system.

I wonder if you can do the kinds of investigations you are talking about without a broad data base that puts everybody in so you can see their practice patterns?

Dr. SCHENKEN. Dr. McDermott, the answer is yes, but it probably won't do everything we want. For example, if we get more uniformity in coding, CPT and ICD–9 in the format in which it is handled, electronic data and so forth, and if we get the ability to utilize practice parameters, AMA's and others, we will be able to pickup the outliers, I think you heard from one of the previous panels where somebody did 10 times as much as every other doctor.

Unfortunately, and I don't have the real data here, but unfortunately, much of that was actually provided. It was not billed and not provided, a lot of that was excess. It doesn't make it right, but it does—it is a separate problem, one that must be addressed. So as I mentioned before, I think in some way, in addition to a better, more uniform, simpler data base, we also, in some way, have to get the patients involved, or somebody else involved, otherwise the services that are billed or not performed are very, very difficult to pickup.

I happen to be serving on several national panels on workers' compensation reform. The health fraud that the chairman knows, that is a big problem in California right now, and the problem there was that everybody was playing with somebody else's money; the workers, the lawyers, the doctors, everybody out there, so nobody cared for a while. Now, everybody is now looking at things and the solution is beginning to be developed because people care.

So I think data base, yes, but in some way we have to get either the patients or the patients' representatives involved as well.

Mr. McDERMOTT. You are suggesting the health care professionals have to be at risk if they are really going to begin to worry about it.

Dr. SCHENKEN. It depends on what you mean by risk.

Mr. McDERMOTT. Somebody else.

Dr. SCHENKEN. They should be responsible for it, yes.

Mr. McDERMOTT. Somebody else is taking their share of the pie by spending too much or drawing down too much.

Dr. SCHENKEN. We would hope the fundamentals of professionalism wouldn't require that. In some cases, it probably does.

Chairman STARK. You guys can fight that out.

Dr. SCHENKEN. Thank you, Mr. Chairman.

Mr. McDERMOTT. Thank you. Thank you, Mr. Chairman.

Chairman STARK. Well, I want to thank the panelists for their willingness to join with us today. I would hope that we can continue to bring the providers and the payers and the Inspectors General or those who would be the enforcers together. We were unable to find any fraudulent abusers who wanted to come and testify for us today, but we know you are out there.

I would hope that we would be able to make it somewhat more difficult for this to go on, because whether or not it affects the health of a lot of Americans, it arguably is costing us billions of dollars every year, and that ought to be incentive enough. I want to thank the Members for coming late in this afternoon, and thank the witnesses very much. I look forward to working with you in the future. The meeting is adjourned.

[Whereupon, at 4:10 p.m., the subcommittee was adjourned.]

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